UNIVERSITY OF ALBERTA

Making Changes in Sharing Control:
A Hospital's Journey to Shared Governance

BY

Leslie Susan Nelson ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTERS IN NURSING

FACULTY OF NURSING

Edmonton, Alberta
Fall 1996

National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-612-18357-2

Canadä

UNIVERSITY OF ALBERTA

LIBRARY RELEASE FORM

NAME OF AUTHOR:	LESLIE SUSAN NELSON
TITLE OF THESIS:	MAKING CHANGES IN SHARING CONTROL: A HOSPITAL'S JOURNEY TO SHARED GOVERNANCE
DEGREE:	MASTER OF NURSING
YEAR THIS DEGREE GRANTED:	1996

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly, or scientific research purposes only.

The author reserves all other publication and other rights in association with copyright in the thesis, and except as hereinbefore provided neither the thesis or any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

Mrs. L. Nelson

Leslie S. Nelson
10028 142 Street
Edmonton, Alberta
T5N 2N5

September 20, 1996

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **MAKING CHANGES IN SHARING CONTROL: A HOSPITAL'S JOURNEY TO SHARED GOVERNANCE** submitted by **LESLIE NELSON** in partial fulfillment of the requirements for the degree of **MASTER OF NURSING.**

Judith Hibberd.

Dr. J. Hibberd (Supervisor)

Patricia Valentine

Dr. P. Valentine

R.H. Field

Dr. R. Field

September 5, 1996

Date

DEDICATION

To my husband, Max, for his patience, love, and support.

ABSTRACT

The purpose of the study was to explore the process used to develop a shared governance model in the nursing division of a large Canadian hospital in order to understand and describe it. Data from 17 informant interviews, participant-observation, and a review of relevant documents were collected and analyzed according to the conventions of grounded theory. The researcher identified a core social psychological process, ***Making Changes in Sharing Control*** (Making Changes) that summed up the essence of what was going on at the study hospital. ***Making Changes*** was a five stage process through which groups of stakeholder representatives transformed stakeholder concerns about the sharing of control into structural changes. Over the three year study period, four complete cycles of the five stage process produced small changes in how control was shared at the study hospital. Cycle specific problems and issues forming the impetus for the change process and four factors impacting movement through the process and choices made are identified. Implications for nurse administrators interested in shared governance systems arise from the evolutionary nature of the process identified and from the integral part played by dissatisfaction in the process.

ACKNOWLEDGMENTS

My sincere thanks to the many individuals at the study hospital who have made completion of this thesis possible: to the Vice-President of Nursing and to the secretaries involved in council minute taking, for allowing me such open access to the various documents and for their helpful hints about "who was in the know"; to the research and development committee for their financial assistance; and most especially to those members of the various councils and task forces who in a time of extreme stress at the study hospital, so willingly participated in the interviewing process.

Thank-you to Jackie Warawa, whose efficient and accurate transcription saved hours of work, and to the Alberta Association of Registered Nurses for their financial support.

My gratitude also to the members of my thesis committee, Dr. Judith Hibberd, my thesis supervisor, and to Dr. Patricia Valentine, and Dr. R. Field, who quietly believed in my ability to complete this study and who allowed me the freedom to find my own path.

A final and very special thanks goes to my husband, Max, for his love, for his constant encouragement to press onward, and for his hard work in reviewing numerous drafts.

TABLE OF CONTENTS

CHAPTER PAGE

I. INTRODUCTION..1

Statement of the Problem..........................1

Purpose of the Study..............................2

Research Questions................................2

Definition of Terms...............................3

Shared Governance..............................3

Significance of the Study.........................3

Background to the Study...........................4

II. LITERATURE REVIEW...................................7

Defining Shared Governance........................7

The Meaning of Shared Governance..............7

The Impetus for Shared Governance.............8

The Structure of Shared Governance............9

Problems and Issues in Model Development.........10

Design Problems and Issues...................10

Who chooses shared governance?.........10

Who designs the model?.................11

Which model is the right model?........11

Implementation Problems and Issues...........13

Acheiving acceptance of the model......13

Sustaining the model...................14

Reaching shared governance goals.......15

Perceptions of Model Development.................17

Gaps in Current Research and Literature..........18

III. METHODS..20
   Research Design..20
      Sampling in Grounded Theory.....................21
         Theoretical Sampling...........................21
         Sample Size...22
         Gaining Access...23
            Factors impacting access..........23
         Data Collection Techniques..............24
         Informant Characteristics................26
      Data Analysis...26
   Trustworthiness..28
   Ethical Considerations..............................29
      Informed Consent.....................................30
      Confidentiality and Anonymity...............30
      Risks and Benefits...................................31
IV. FINDINGS..32
   Emergence of the Core Process..................33
   Five Distinct Stages in *Making Changes*...........35
      The Stages Defined...................................36
         Stage 1: Expressing dissatisfaction....36
         Stage 2: Signalling commitment.........37
         Stage 3: Identifying common values.....38
         Stage 4: Making a blueprint...........39
         Stage 5: Establishing the changes......39
      Movement Through the Stages 40
   Five Cycles of *Making Changes*..................42

Cyclical Variations Defined................42
Cycle A: Renovating the old model......42
Cycle B: Committing to a new model.....46
Cycle C: Building a new structure......49
Cycle D: Defining decision-making......58
Cycle E: Renovating the new model......62
The Evolutionary Nature of *Making Changes*........65
Influencing Factors...........................65
The Economic Climate.......................67
Stakeholder Values and Beliefs..............69
The Nature of Stakeholder Relationships.....71
The Actions of the VPN.....................73
Summary.......................................75
V. DISCUSSION......................................77
The Findings and Current Literature.............77
The Process as a Series of Stages...........77
Support for the Staged Process Identified...78
The Unique Nature of the Evolutionary Process..............................79
The Political Nature of the Process.........80
The Importance of Identifying Common Values..............................80
Facilitating and Constraining Factors.......82
Propositional Statements......................85
Nursing Implications...........................87
Nursing Administration and Nursing Staff....87

Nursing Research..........................88
Strength and Limitations.........................89
Summary.....................................92
REFERENCES..93
APPENDICES..105
A Letter of Introduction..............................105
B Consent Form......................................106
C Letters of Support................................108
D Examples of Guiding Interview Questions...........109
E Subject Face Sheet................................110
F Summary of Informant Face Sheet Values............111
G Informant Involvement in the Development of Shared Governance..112
H Quotation Reference System........................113

LIST OF FIGURES

FIGURE DESCRIPTION PAGE

1 Five Stages in the process of *Making Changes in Sharing Control*....................................41

2 A time line of five cycles of *Making Changes* occurring during the study period...................43

3 Cyclical repetitions of the five stage process.......66

CHAPTER I

INTRODUCTION

Implementing a shared governance model in a hospital setting is a transformational experience. It is a journey of change that leads away from the traditional bureaucratic model characterized by centralized authority and accountability to a model in which "nurses at every level play a role in the decisions that affect nursing activity" (Porter-O'Grady, 1989, p. 1). Institution of this new management system in American nursing divisions began in the early 1970s in response to growing demands by staff nurses for some say in practice-related decisions and as a solution to ongoing problems with nursing recruitment and retention. It was not until 1991, however, that reports of models in Canadian hospitals began to appear in the literature (see, for example, Burke, 1991; Hibberd, Storoz, & Andrews, 1992; Perry & Code, 1991). It would appear that abandoning the traditional pattern of top-down decision-making and embracing staff involvement in decision-making is a somewhat new phenomenon in Canadian nursing divisions. The subject of this research is the process of developing a shared governance model in one Canadian nursing division.

Statement of Problem

Two problems confront nursing divisions seeking to make the change to shared governance. First, the change is extremely complex. As stated by Krueger Wilson (1989), "the relearning inherent in a shift to shared governance requires significant changes in organizational structures and processes" (p. 29). It is "a systemwide experience" (p. 29) that requires changes in behaviours and relationships, and that creates considerable ambiguity in decision-making. Second, there is little information in the published literature and in research in health care settings on the actual process used to develop such a model. All of the studies identified in a preliminary review of the literature focussed exclusively on outcome measurement (see Chapter II). An additional concern for Canadian nursing divisions that was rarely addressed in the literature, was what impact the presence of a highly unionized nursing work force might have on the process and particular model developed. It would appear that the process of developing a shared governance model in a health care setting is an unexplored phenomenon. There is a need for an exploratory study using a qualitative research approach to gain an understanding of the process.

Purpose of Study

The purpose of the study was to explore the development of a shared governance model in the nursing division of a large Canadian hospital in order to understand and describe it.

Research Questions

Initial questions formulated to guide the research were:

1. How did participants decide what structures and

processes would form the basis for decision-making in their model of shared governance?

2. What problems and issues did they encounter in developing these structures and processes?

3. What were the salient factors influencing the development of these structures and processes?

Definition of Terms

Shared governance

Using a classification scheme for participatory decision-making developed by Locke and Sweiger (1979), the researcher defined shared governance as a type of participatory decision-making characterized by voluntary initiation, formal structures, and indirect representation. For the purpose of this study, shared governance was therefore construed as participatory decision-making that was agreed to by management and accepted by employees and that involved the creation of formally recognized decision-making bodies composed of elected employee representatives.

Significance of the Study

This study becomes significant for several reasons. First, the study adds to the general body of knowledge on shared governance by its focus on process and not on outcome. Second, the conceptual model developed provides a basis for further research aimed at refinement and verification. Third, it is hoped that the process described may prove insightful for nurse administrators interested in shared governance systems. Finally, though the case study approach limits generalizability in the strictest sense, it is hoped that the conceptual model developed may be transferable and useful in nursing divisions contextually similar to the study situation.

Background to the Study

The study was conducted in a large tertiary care teaching hospital located in Western Canada. The study hospital provides a full range of services including intensive care and emergency services, general surgical, medical, obstetric, and pediatric care as well as a variety of speciality clinics. In the nursing division, the nursing staff are predominantly registered nurses functioning in a total care delivery system. A nursing union represents the 1900 staff nurses in the collective bargaining process.

A change in corporate values in the greater organization initiated prior to the study period supported the beginning of a "new management paradigm", that encouraged more open communication and staff involvement in decision-making. Incorporation of a new organizational program - Quality Improvement- perpetuated this shift in values and resulted in the identification of three core values to guide organizational decision-making: respect, partnership, and continuous improvement.

At the time of the study the nursing division was in the early stages of implementing a shared governance approach. The original model (the Old Model) developed and initiated in 1988 by the Vice-President of Nursing (VPN), consisted of a central council to which the various nursing committees reported. Council membership consisted of appointed members from all levels of nursing and from the nursing union. Decision-making occurred by vote, with the central council retaining final approval.

In 1990 the nursing division underwent a change in nursing leadership. This study focuses on the development of shared governance from the beginning of the new Vice-President's term in June 1990 to August 1993 when active participation in the model halted. In July 1993, one month into the study, the hospital announced restructuring plans that eliminated the nursing division, initiated layoffs of nurses at all levels, and raised questions regarding the continuance of the current governance model in the new structure.

Key developmental events during the study period included the formation of two representative task forces to design a new governance structure and to identify how decision-making would occur (identified respectively as the Structure Task Force and the Decision Task Force); a staged implementation of the new model (New Model) beginning in July 1992; and operation of the complete model from January to August 1993. In summary, though implementation of shared governance had begun as early as 1988, the period of the study was a time of intense activity resulting in significant changes in how shared governance was enacted at the study hospital.

Before beginning the study and at the conclusion of the study, the researcher conducted a review of relevant literature and research on models of shared governance in various settings. The next chapter is a summary of that review.

CHAPTER II

LITERATURE REVIEW

Descriptive and research literature on shared governance was reviewed prior to and at the end of the study to identify current knowledge on model development. This chapter is a summary of both reviews. Sources searched included the computer data bases of CINAHL, ERIC, HEALTHPLAN, and ABI; a CD-ROM search of Dissertation Abstracts International; and a manual search of the Index of Canadian Nursing Research and the Journal of Management Studies. A classification scheme for participatory decision-making identified in Chapter I was used as a base to identify synonymous names in the various literature bases. Synonymous terms in the educational literature included shared governance, shared decision-making (SDM), and school-based management (SBM). In the business literature synonymous terms included self-managed teams, self-designing teams, and self-leading teams (Manz 1990, Hackman, 1976). Three sections comprise the review: defining shared governance; problems and issues in model development; and perceptions of model development.

Defining Shared Governance

The Meaning of Shared Governance

A definition of shared governance by Porter-O'Grady (1989) represents a participatory ideal that many models in the nursing literature aspired to:

> Nurses belong to key decision-making groups that deal with issues of practice, quality of care, personnel issues, staffing, scheduling, recruitment, education, and evaluation. They do not need to present their ideas to management; they themselves have the power to implement their decisions in the clinical arena (p. 351).

Several authors suggested that relinquishment of the traditional power of veto by the Chief Nurse Executive was in keeping with this shared governance ideal (Jacoby & Terpstra, 1990; McMahon, 1992; Porter-O'Grady & Finnegan, 1984). Support for this ideal definition occurred in both the business (Manz & Sims, 1987; Manz 1990) and educational literature. As described by Allen (1991), a basic operating principle of the League of Professional Schools was that the shared governance process developed by each school "should not give ***any individual*** [italics added] ultimate authority or veto power over areas targeted for shared governance" (p. 3).

The Impetus for Shared Governance

In educational settings the primary goal for implementing shared governance was to improve student performance (Lundsford, 1993; Center on Organization and Restructuring of Schools, 1992; Short & Greer, 1989; Smith 1993). As stated in a 1992 report by the Center on Organization and Restructuring of Schools, "education is more likely to serve the needs of students if the most important issues for schools . . . are decided by adults who know these particular students best" (p.2). In the nursing literature, implementation of a shared governance model commonly occurred to satisfy staff nurses' desire for professional practice. Under shared governance staff nurses would have the authority and autonomy to make decisions about nursing care. Other goals identified by shared governance advocates included improved patient care (Maas, 1989; Mullins Moore, Morselander, & McDonagh, 1990; Zelauskas & Howe, 1992) and reduced turnover and increased recruitment resulting from a more satisfied nursing staff (Gyongyous, 1988; Deremo 1989; Jones, Stasiowski, Simons, Boyd, & Lucas, 1993; Ludeman & Brown, 1989; McDonagh, Rhodes, Sharkey, & Goodroe, 1989). Except for professional practice, similar goals were identified in the business literature.

The Structure of Shared Governance

Porter-O'Grady (1987) and Foster (1992) have identified four basic models of shared governance common to nursing service settings: councilar, congressional, administrative, and unit-based. The councilar model has a system of staff nurse clinical councils; a management council to manage "the fiscal, human, and material resources for the institution" (Foster, 1992, p. 98); and a coordinating council involving both staff and management. The congressional model operates in a fashion similar to the "constitutionally empowered representative system of the government" (Porter-O'Grady, 1987, p. 284), while the administrative model follows the "more traditional lines of separation between management and practice" (Foster, 1992, p. 101). As described by Foster, unit-based models are simpler in design and lack the central integrating function of the other models.

Porter-O'Grady (1987) has suggested that the councilar model is the most frequently used model in nursing service settings. In educational settings, a mixture of the congressional (Firestone & Bader, 1991), administrative (Malen & Ogawa, 1985, Sidener, 1995) and councilar models (Reece, 1991; Smith, 1993) occurred. The self-managing teams described in research by Manz and Sims (1984, 1987) were similar to unit-based models.

Problems and Issues in Model Development

According to the literature, problems and issues may occur during the design process and during ongoing implementation of shared governance models.

Design Problems and Issues

Who chooses shared governance? Most authors in the nursing literature indicated that the Chief Nurse Executive(s) introduced and made the final decision to implement shared governance. Although this sounds contradictory to the idea of staff decision-making, as explained by Smith (1992) the reality is that "the senior nurse administrator is the only one who has the authority and power to restructure the organization" (p. 116). Government mandated shared governance was a notable exception described by Monk (1994). A bill passed in the Quebec Assembly in 1991 requires the formation of a "Council of Nurses for every public institution employing 5 nurses" (p. 207). Similar initiation reports occurred in the educational literature. In industry, the changes were management driven (Manz & Sims, 1987).

Who designs the model? Authors in the nursing literature commonly described designing of the shared governance model as a group process that involved members from all levels of the nursing division. As indicated by Shidler et al. (1989), "involving professional nursing staff from idea inception to implementation" (p. 7) was necessary to ensure staff ownership and commitment to the model. Variation occurred in three models described by Burke (1991), Mullins Moore et al. (1990), and by Perry and Code (1991). In these models the Chief Nurse Executive or a team of nurse administrators identified the initial pattern. Staff involvement in the design group also occurred in educational settings. A notable exception was a model design mandated by school district policy (Byrk, Easton, Kerbow, Rollow, & Sebring, 1993) or by school reform legislation at the state level (Malen & Ogawa, 1985).

Which model is the right model? Several authors in both educational and nursing settings indicated that the design group's common vision of change had a major impact on the particular model chosen (Davis, 1992; Glickman, Allen, &

Lunsdford, 1992; McDonagh, 1990; Reece, 1991; Walker et al., 1994). Other factors influencing design changes in nursing divisions included existing organizational structures (Shidler, Pencak, & McFolling, 1989); staff experience (Deremo, 1990); the Chief Nurse Executive's preference for a particular model (Burke, 1991); and the need to follow structural guidelines mandated by legislation (Monk, 1994).

Membership issues included finding the appropriate balance of management and staff representatives (Deremo, 1990) and determining the maximum number of members feasible for equitable representation and timely decision-making (Twite et al., 1993). Another issue identified by Hibberd et al. (1992) was the need to include "card-carrying members" of the Nursing Union to ensure representation of the official union perspective in decision-making.

As described in a study of SDM implementation in 24 schools, model design flaws can create decision-making problems (Allen, 1991). Confusion resulted when the process of shared governance was "simply added on" to the existing structure "with no clarification as to what existing procedures, if any, it was to replace" (p. 3). Additional problems arose from the lack of a clearly defined decision-making process. As suggested by Allen (1991), participants needed to understand how decisions were to be made (by consensus or by majority vote); what steps were to be followed in making a decision; and what degree of group decision-making authority could be expected (advisory or final decision-making). Limitations placed on direct staff involvement in unionized organizations was an additional issue mentioned by several authors (Burgett, 1993; Conley, 1993; Hibberd et al., 1992; Oswald, 1995; Short & Greer, 1989). A final issue summarized by Oswald (1995) related to decision-making accountability:

> A school may want authority over decisions, but the public (and state statues) will still hold the school board accountable for the results of those decisions (p. 3).

Implementation Problems and Issues

Achieving acceptance of the model. In a phenomenological study by Stichler (1989), informants involved in three hospital-based models described shared governance as "a completely different mind set than any other management structure" (p. 3). Achieving acceptance for this new mind set is one of several problems encountered. As suggested by Pinkerton et al. (1989), "Not everyone welcomed shared governance or saw it as an improvement" (p. 12). Management holding onto control was a common problem described throughout the literature. As reported in a study on the changing role of principals by Lundsford (1993), "It took time for the principal to able to sit back . . . when in the past the decisions would have been made quickly without input" (p. 15).

Reports of resistance from unions officials unwilling "to get into bed with management" (Hibberd et al., 1992, p.

18) in one unionized hospital, contrasted with the experience reported in a school-based study. As described by Bondy et al. (1994), the teacher's union participated actively in a decision to introduce "shared decision-making" in three schools.

Sustaining the model. The presence/absence of administrative financial and psychological support significantly impacted the model's continuance. As suggested by Smith (1992) and supported by others in the nursing (Edwards et al., 1994; Deremo, 1990) and educational literature (Bredeson, 1989; Chion-Kenney & Hymes, 1994; Johnson & Ledbetter, 1994), financial support included the ongoing allocation of funds to provide shared governance orientation for staff and management; to equip staff with the necessary skills to function successfully in the new system; and to pay for staff attendance at governance meetings. A hold placed on SBM activities due to a loss of funding reported in a study by Bondy et al. (1994) demonstrates the importance of financial support.

Psychological support included administrators role modelling the changes in relations and decision-making, and protecting the shared governance system. The significant impact of administrative support on SDM was evident in the findings of a study reported by Sidener (1995):

> At the beginning of SBM/SDM, the district superintendent gave authority to SBM/SDM schools, provided visible support and removed them from the constraints of the district bureaucracy. In successive years the

> effectiveness of Royal Palm's SBM/SDM process eroded as authority was assumed by others: by the district under the auspices of a new superintendent, then by the new principal, and in Year Six, by the state (p. 25).

The presence of a supportive/non-supportive union also influenced model continuance. As suggested by several authors (Conley, 1993; Foster, 1992; Lawler & Mohrman, 1987; Porter-O'Grady, 1992; Twomey, 1991) supportive unions committed to new relationships. These relationships involved win-win negotiation (Conley, 1993) and contracts focussing less on rigidly defining details and more on defining the parameters of the participatory relationship (Lawler & Mohrman, 1987; Porter-O'Grady, 1992; Twomey, 1991). The impact of non-supportive behaviour was described in one study. A union work-to-the-rule order arising during difficult negotiations, shortened SDM council meetings to the point of making them ineffective (Bondy et al., 1994).

Reaching shared governance goals. The primary issue evident in research on hospital-based models was whether a shared governance system achieved expected outcomes. Findings varied regarding the impact on professional practice of shared governance implementation. In a study by Havens (1990; 1994), Chief Nurse Executives of 221 American hospitals completed self-report questionnaires on the degree and areas in which governance was shared. Even in units viewed as the most "professional/innovative"(p. 60), little change in governance practices occurred. As described by Havens,

> authority [mainly] rested with managers/administrators, with some staff input. In no area were staff nurses exerting primary authority . . . (p. 62).

Similar findings were reported in two other hospital-based studies (Daniel, 1994; Minors 1993) and in three school-based studies (Malen & Ogawa, 1985; Murphy, 1995; Nolte 1994). As described Malen and Ogawa (1985),

> the principals [continue to] exert substantial influence on the composition of the site councils, on the establishment of agendas, . . . and [on] the final decisions of site councils. (p. 37-38).

Other researchers reported positive perceptions (Chorewycz, 1994; Mancini, 1994; Reece, 1991). Participants in Reece's case study, for example, described shared decision-making as the "modus operandi". Variation in staff perceptions of decision-making involvement within particular models was also reported (Allen, 1991; Hastings & Waltz 1995; Mahugh, 1993; Smith 1993).

Only one study focussed specifically on the impact of shared governance on patient outcomes. Results of the four year study reported by Maas (cited in Maas, 1989) included increased feelings in patients of personal control and increased satisfaction with their care. A case study by Motz and Lewis (1994) provided specific examples of the positive impact of shared governance implementation on patient care. Reports of improved production in three studies on self-lead teams (Coradetti, 1994; Graham, 1992/1993; Luken's Steel CO., 1996) were questionable, given a failure to account for the impact of other intervening variables on production. In a quasi-experimental study on the effectiveness of self-managed teams, results were inconclusive (Cohen & Ledford, 1994).

Several researchers of hospital-based models reported significant post implementation decreases in turnover (Ethridge, 1987; DeBaca, Jones, & Tornabeni, 1993; Porter-O'Grady & Tornabeni, 1993; Westrope, Vaughn, Bott, & Taunton, 1995). Here as well, the researchers attributed improvements to shared governance implementation without attempting to account for the potential influence of other intervening variables.

Perceptions of Model Development

The trend identified in the descriptive literature was to view development of a shared governance model "as a process - a series of changes [occurring over a 3-10 year period] that led to the end goal of shared decisions" (Eckes, 1988, p. 124). Some authors used pre-existing theory such as Lewin's change theory (Caramanica & Rosenbecker, 1991; Houston & Green, 1993; Perry & Code, 1991; Twite et al., 1993) or Ferguson's paradigm shifting (Pinkerton et. al., 1989) to describe the developmental process. Others defined steps (Deremo, 1989; Jenkins, 1991; Peterson & Allen, 1986b) or phases arising out of particular experiences in model development (Smith 1992). The four phases identified by Smith (1992): Plan Development; Chaos, Confusion, and Uncertainty; Development, Regrouping, and

Clarification; and Integration, Refinement, and Continued Evolution, offered the most comprehensive view of the ongoing nature of the developmental process.

No studies were noted that defined the specific process used to develop particular models of shared governance. Burgett (1993), in a project thesis, identified seven steps used to design a model in a community hospital. Findings reported in McLean's (1995) hospital-based study included a description of the design process used in a unionized hospital. Perceptions of the ongoing developmental process, however, were limited to a case study of shared governance in one school (Reece, 1991). As described by Reece, the process was "an inductive, searching, developmental approach to fundamental change" (p.10).

Gaps in Current Research and Literature

It would appear from this review of the literature, that the process of developing a shared governance model is a complex undertaking that goes beyond designing the initial model. Rather, it is a process of ongoing development that involves a 3-10 year commitment to effect the necessary changes in roles and relationships. Understanding of this developmental process is constrained, particularly in health care settings, by research that focusses on outcome and not on process. A particularly significant gap for Canadian institutions is the lack of information on the role of unions in the developmental process.

In conclusion, the process of developing a shared governance model remains a largely unexplored phenomenon. Research is needed to foster understanding of the process. The knowledge gained through such research may be beneficial to nursing administrators interested in or already involved in developing such systems. The following chapter details the qualitative approach taken by the researcher to address this need for research.

CHAPTER III

METHOD

Research Design

The purpose of the study was to describe the process used to develop a model of shared governance in the nursing division of a large Canadian tertiary care hospital. The unknown nature of the phenomenon evident in a preliminary literature review, combined with the researcher's intent to move beyond simple description prompted the choice of a qualitative research approach called grounded theory as the appropriate method. In grounded theory the empirical, experiential, and descriptive knowledge of the "man [woman] in the know" is transformed into a theory that gives conceptual order to what is happening in the area under study (Glaser, 1978, p. 13). The method involves a systematic approach to generating theory from data that uses both inductive and deductive processes. As described by Field and Morse (1985), the process is inductive in that "constructs and concepts are grounded in the data" and deductive in that "hypotheses are tested as they arise from the research" (p.23).

In this chapter the researcher's application of grounded theory is explained. Though grounded theory involves concurrent sampling and data analysis, for purposes of clarity these procedures are described separately. The chapter also contains a description of the researcher's efforts to ensure trustworthiness of the data and to address ethical concerns.

Sampling in Grounded Theory

Theoretical Sampling

In grounded theory, "the initial sample is determined to examine the phenomena where it is found to exist" (Chenitz & Swanson, 1986, p. 9). General selection criteria for initial informants therefore became members of the Nursing Division at the study hospital who:

1. had participated in the development of the shared governance structures and processes.
2. were willing to share with the researcher their experiences in the model's development.

Knowledge arising from the researcher's position as a staff nurse at the study hospital facilitated the choice of two initial informants with broad experience in the various developmental activities. The interviews began by focussing on the process used by two task forces (see Chapter I) to design the structures and processes of the new model. A preliminary review of task force minutes served as an additional source of information.

Subsequent to obtaining the initial sample, sampling in grounded theory proceeds theoretically. As stated by Glaser (1978),

> theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and [then] decides what data to collect next and where to find

> them, in order to develop his theory as it emerges (p. 36).

Analysis of the initial interviews suggested an evolutionary dimension to the process of developing a shared governance model that prompted new directions for sampling. Data collection therefore broadened to include a review of old and new model minutes; participant-observation of the new model's divisional level councils; and procurement of informants who were members of the new councils. In total 17 interviews were conducted of which 7 were follow up interviews aimed at clarifying emerging concepts. Three of these seven interviews occurred after a central concept had begun to emerge from the data. Informants for these "verifying" interviews consisted of a staff nurse, a nurse manager, and a nursing director, each of whom had broad experience in the development of the shared governance model. A diagram of the emerging conceptual model and a chart of relevant factors and significant problems and issues, were explained and validated in the ensuing discussion. Development of the final model occurred during further theoretical sampling and analysis at the completion of all informant interviews.

Sample Size

Stern (1985) states that a satisfactory sample contains answers to the researcher's questions such that "he or she is satisfied that a conceptual framework is developed that is integrated, testable, and explains the problem; in other words, the truth" (p. 154). In this study 17 interviews with 10 informants in conjunction with the additional data sources provided an adequate data base for category saturation and development of the initial theory.

Gaining Access

Following ethical clearance and approval, the researcher sought access to the various data sources. In addition to the researcher's personal knowledge, a review of task force and council membership lists and recommendations from informants during the interview process aided the selection of potential informants. A brief letter sent to potential informants at their place of work introduced the researcher, described the study, and asked interested parties to contact the researcher (see Appendix A). Of 16 potential informants contacted, 10 participated, 4 refused, and 2 did not respond. After obtaining verbal assent, the researcher made an appointment to obtain written consent (see consent form in Appendix B) and subsequently to conduct the first interview. In addition to letters of support (See Appendix C), verbal consent from the Vice-President of Nursing and council chairpersons allowed access to relevant documents and observation of the divisional level councils.

Factors impacting access.

Workload demands arising from an economic crisis at the study hospital delayed access to two informants, precluded two others from participating, and was likely a factor in the refusal of union officers to act as informants. As well, in August 1993, a hold on governance activities until hospital restructuring initiatives were complete, prevented ongoing observation of the new model councils.

It is unknown what impact the researcher's past employment as a nurse manager in the study hospital may have had on the decision of staff nurses and union members to participate as informants. Past positive relationships and the researcher's current employment did facilitate access to management informants and resulted in strong support from the Vice-President of Nursing for the study. Of the 10 informants who took part in the study, 4 had never met the researcher and 6 had worked with the researcher in a variety of relationships ranging from staff nurse and nurse manager peers to being in a supervisory position to the researcher.

Data Collection Techniques

The researcher found, as suggested by Glaser and Strauss (1967) that in theoretical sampling,

> no one kind of data on a category nor technique for data collection is necessarily appropriate. Different kinds of data give the analyst different views or vantage points from which to understand a category and to develop its properties (p. 65).

Data collection techniques used in this study to obtain these different views included: informant interviewing; participant observation; and document review.

The researcher used semistructured interviews in an attempt to achieve a balance between becoming immersed in the "life-world of the interviewee" (Becker, 1986, p. 109) and remaining focussed on the purpose of the research. Recognizing that the semistructured interview is "neither a free conversation nor a highly structured questionnaire" (Kvale, 1983, p. 174), before each interview the researcher developed a list of guiding questions to facilitate the interview process. In keeping with theoretical sampling these questions necessarily changed, both in content and in specificity, as the research process progressed (Morse & Johnson, 1991). See Appendix D for a list of questions developed for the initial interviews.

Besides the tape-recorded interview, initial contact with each informant included answering informant questions about the interview process, collecting biographical information, and determining the informant's interest in further participation. Interviews averaged 1 - 1 1/2 hours and were conducted in a quiet, private place chosen by the informant. Fieldnotes completed after each interview provided information about the setting and about non-verbal cues, such as posture or gestures, indicative of the informant's comfort level. These notes assisted the researcher to mentally reconstruct the interview context during later review of the tapes and transcripts.

The researcher observed an 8 hour meeting of three of the four New Model divisional councils, beginning in June and ending in July 1993. The objectives of the observational experience were: (a) to observe for evidence of ongoing model development alluded to in the first interviews, (b) to publicize the research project, and (c) to increase researcher exposure to potential informants. Given the retrospective nature of much of the study, the researcher was concerned that informant recall would be diminished, resulting in a loss of valuable data. Analysis therefore also included minutes of the various governance councils, committees, and task forces and relevant correspondence.

Informant Characteristics

Biographical information was collected using an informant face sheet (see Appendix E) and a tape-recorded response to two open ended questions. Of the 10 informants, all were female, 6 were management staff, and 4 were staff nurses. See Appendix F for information on the informant's years of nursing experience, years employed in the study hospital, and level of educational preparation. Appendix G. contains a summary of the informant's involvement in the various task forces and councils.

Data Analysis

Data analysis in grounded theory is a systematic and simultaneous process of theoretical sampling, coding, memoing, and diagramming. In keeping with the conventions of grounded theory, coding of the interviews began with substantive coding or giving labels to pieces of the data that reflect the same substantive area, and proceeded to theoretical coding or establishing how the substantive codes related to each other (Glaser, 1978). As suggested by Glaser (1978), in substantive coding the researcher asked three questions:

1. What is happening here?
2. What name (or code) describes what is happening here?
3. "What category or property of a category, of what part of the emerging theory, does this incident indicate?" (p.57).

Use of the Ethnograph computer program facilitated grouping of the substantive codes into larger categories. The program allowed the researcher to view and print-out instances of a particular code for comparison within and across interviews. In this manner redundant codes were eliminated, while other codes remained as properties of the newly generated larger category.

Theoretical coding began as the researcher began to hypothesize linkages between the various categories. Return to the various data sources confirmed or modified these linkages. Memoing intensified during this period accompanied by many attempts to develop a simple diagram to represent visually the relationships. Through this process a core category, ***Making Changes in Sharing Control***, eventually emerged. Coding then became more selective, aimed at refining only those categories with continuing relevance.

A review of interview data and applicable documents ensued. When no new information was forthcoming the categories remaining were viewed as theoretically saturated and further coding ceased. In the process of writing up the findings, the intimate relationship between the various categories stabilized into its final form.

Trustworthiness

Issues of validity and reliability were addressed using Lincoln and Guba's (1985) framework for assessing the trustworthiness of qualitative research: credibility; transferability; dependability or auditability; and neutrality. As stated by Sandelowski (1986), a study is credible "when it presents such faithful descriptions or interpretations of a human experience that the people having the experience would immediately recognize it . . . as their own" (p. 30). Procedural strategies used to enhance credibility throughout the study included (a) informant checks to verify data interpretations and conclusions; (b) informant review and correction of transcripts before analysis to ensure that comments reflected the intended meaning; (c) preference given to information obtained from primary informants, that is, those directly involved in the event; (d) accessing of multiple data sources to ensure accuracy of informant reports and to maximize the range of data for analysis; and (e) use of a personal diary to encourage the researcher to "become aware of biases and preconceived assumptions" (Krefting, 1991, p. 218).

Approval of the researcher's portrayal of the informant's reality was also obtained in verifying interviews in which three informants concurred that ***making changes in sharing control*** was at the heart of the developmental process. Additional support for the "sensibility" of the findings came through informal discussions at the end of the research process in which the core process of ***Making Changes*** was reviewed with staff nurses at the study hospital who had not been informants.

The criteria of transferability was met by providing biographic data on the informants and background information on the study hospital. Dependability or auditability will be achieved by the storing of raw data and analytical records developed throughout the course of the study for seven years. This will allow another researcher to follow the decision trail used in the study should further verification of the findings be desired. In the course of the study a safeguard for dependability was researcher verification of transcription accuracy before analysis. Neutrality refers to the freedom from bias in the research process and findings and is assumed if the criteria of credibility, transferability, and auditability are met (Sandelowski, 1986).

Ethical Considerations

Prior to conducting the study the researcher obtained ethical approval from the University Faculty of Nursing and from study hospital research committees. Ethical considerations included obtaining an informed consent, assuring confidentiality and anonymity, and explaining risks and benefits.

Informed Consent

According to Robinson and Thorne (1988), obtaining an informed consent can be problematic in qualitative studies, because "the nature of qualitative inquiry precludes prior knowledge of precisely what will occur in the context of the research encounter" (p. 66). Though written consent was obtained from the informants, the expectation was that consent would be a product of ongoing negotiation.

Confidentiality and Anonymity of Informants

While the researcher could not prevent speculation about the identity of informants, confidentiality and anonymity of informants was guaranteed by the researcher. Names of informants were not disclosed by the researcher. During the consent process informants were also made aware of the following strategies aimed at identity protection: (a) use of identifying codes, known only to the researcher, on transcripts and audiotapes; (b) use of pseudonyms for quotations in publications and presentations; (c) separate locked storage of the informant's informed consent and face sheet from the audiotapes and transcripts; and (d) storage of all material in locked file cabinets when not in use.

Informants were aware that upon the study's completion the audiotapes would remain in locked storage in the researcher's home or office for seven years, in accordance with University policy, and then be destroyed by the researcher. Informants also were advised that the typed transcript and notes would remain a locked file cabinet, indefinitely.

Risks and Benefits

This study benefitted the study hospital in two ways. First, it provided documentation of some salient factors influencing redesigning over the study period. Second, it provided a perspective on the ongoing development of shared governance from June of 1990 to August of 1993. Both benefits fit with the study hospital's intent to conduct research on the model at different points in the time continuum of its development.

Study informants did not receive any remuneration or benefits from participating in this study, nor were they knowingly exposed to any personal risk. In consideration for the informant's contribution to the study, however, informants were offered the choice of whether or not to receive a mailed copy of the study results.

In the next chapter, the findings that relate to the core category of ***Making Changes in Sharing Control*** are presented.

CHAPTER IV

FINDINGS

This study was an investigation of the process used by nurses to develop a shared governance model in a large Canadian tertiary care hospital. Though a shared governance model designed by the incumbent Vice-President of Nursing (VPN) had been operating since 1988, the particular focus of this study was on development of shared governance under the auspices of a new VPN from June 1990 to August 1993. Initial questions formulated to guide the research were:

1. How did participants decide what structures and processes would form the basis for decision-making in their model of shared governance?
2. What problems and issues did they encounter in developing these structures and processes?
3. What were the salient factors influencing the development of these structures and processes?

As indicated in Chapter I, the study period was a time of intense activity resulting in significant changes in how shared governance was enacted at the Study Hospital. The original model (Old Model) at the beginning of the study period consisted of a central council of appointed staff and management members chaired by the VPN, to which the various nursing committees reported. Key developmental events over the study period included the formation of two task forces, identified as the Structure Task Force and the Decision Task

Force, to design and implement a new governance structure (the New Model) and to define how decision-making would occur. Implementation of the New Model was completed by January 1993. The Study Hospital's core values of respect, partnership, and continuous improvement (Appendix C, Study Hospital Quality Improvement Plan, March 1990), were consistent with these ongoing efforts in the nursing division to increase staff nurse participation in decision-making.

In keeping with the intent of the grounded theory method, the researcher identified a core category/process, ***Making Changes in Sharing Control (Making Changes)***, that captured the essence of what was happening as participants continued to develop their shared governance model. In this chapter the findings that relate to this core process are presented. Discussion begins with emergence of the core process and proceeds to identification and description of the process's key characteristics and four major influencing factors. Bold italics are used to identify the core process and to distinquish key properties of the category under discussion.

Emergence of the Core Process

The central problem for participants in developing their shared governance model was ongoing confusion about how control over decision-making was to be shared in the governance model. Informants agreed that the implementation of shared governance was an attempt to move away from the "old [bureaucratic] structure" characterized by "centralization", "top-down" decision-making, and "autocratic" behaviour by management (I03-01: 1419-1421) to a model that offered staff nurses more involvement in decisions made in the nursing division (See Appendix H, for an explanation of the referencing system for informant and document quotations). Confusion was evident, however, in interpretations within the various stakeholder groups about what increased staff involvement meant. While one management informant suggested that "there are certain decisions that a manager will always make" (I01-02: 533-535), another informant indicated that "some [staff nurses involved in the New Model] felt they would be making every decision right now" (I05-01: 970-971). One informant described the situation under the Old Model, as "chaotic" (BI0-08-01: 125), while another informant involved in the New Model admitted that "there is [still] confusion over decision-making" (I04-01: 603-604). Participants attempted to deal with this confusion and the ensuing dissatisfaction by engaging in a repetitive pattern of behaviour that focussed on making adjustments in how control was shared. The researcher concluded that the core category that summed up the essence of "what [was] going on in the data" (Glaser, 1978, p. 94) was ***Making Changes in Sharing Control***. Making changes in sharing control referred to making modifications in how control was exercised in the governance model, to reorganizing who had control over which decisions, and to clarifying what having control meant in terms of decision-making power. Achieving desired changes in the state of control involved progression over time through five definable stages. ***Making Changes in Sharing Control*** was therefore a core social psychological process. Identification and description of the five stages and of the process's cyclical and evolutionary nature follows.

Five Distinct Stages in *Making Changes*

The five stages identified were: **Expressing Dissatisfaction; Signalling Commitment; Identifying Common Values; Making a Blueprint;** and **Establishing the Changes**. Each stage represented a distinct action by a particular group related to the sharing of control. **Dissatisfaction** with the sharing of control expressed by stakeholder groups gave rise to the process of ***Making Changes***. Positive **signals of commitment** in the nursing division to stakeholder requests for changes in sharing control moved the process forward. **Identification** in the responsible work group of some **common values** about what changes in sharing control should occur, formed the basis for redesigning decisions and for work group behaviour in subsequent stages. **Making a blueprint** by the work group resulted in a plan for changing the sharing of control, and work group efforts to **establish the changes** put the plan for making changes into action. In the next section these five stages are described more fully.

The Stages Defined

Stage 1: Expressing dissatisfaction.

In stage 1 stakeholder groups identified and communicated ***problems and issues*** with the sharing of control to groups with the formal authority to act. A ***stakeholder group*** was a group with a vested interest in any changes made to the sharing of control. Over the study period stakeholder groups identifying concerns included the Nurse Administrator group, the Nurse Manager group, the Nurses Union, and staff nurse council members. ***Groups with formal authority*** generally referred to a governance model council, or to a group with delegated decision-making authority such as the Structure Task Force. ***A problem*** was a concern in which stakeholder groups agreed that the sharing of control was inappropriate. A problem in the New Model, for example, centered on improper representation by governance council members. As one informant said, unit representatives

> needed to be re-instructed that they represent their [unit] council [at the divisional council meetings] and not their personal response (I02-01: 144-146).

An issue was a concern involving different opinions in the stakeholder groups about what constituted appropriate sharing of control. The membership and role of managers in the New Model was an issue for Structure Task Force members. As one informant recalled, other members disagreed with the concern expressed by the nurse manager representative that limiting manager involvement in the New Model to the unit councils meant that "nurse managers had no voice at the divisional level" (I07-01: 585-587). Over the study period ***problems and issues*** focussed on the sharing of control in the governance model and in decision-making by the VPN/nursing administration, the nursing union, and the corporate division. This stage ended when the group with formal authority reached agreement that a ***certain problem(s)*** with sharing control existed.

Stage 2: Signalling commitment. Stage 2 began when ***groups with formal authority*** indicated their intent to respond to the problem with sharing control agreed upon in stage 1. ***Positive signals*** were favourable responses that moved the process forward. Examples of favourable responses included a decision to function as the responsible work group or to form new work groups (e.g. the Structure Task Force) to solve the problem. ***Negative signals*** were unfavourable responses that slowed or halted progression. An example of a negative signal from a ***group with formal authority*** was the decision by the New Model Governance Council members at the end of the study period to put a hold on governance activities until organizational "restructuring has been settled" (Letter to Nursing Administration from Divisional Council Chairpersons, August 18, 1993). As one informant involved in the New Model said,

> I really think we're kind of in this phase where we are not going anywhere (I03-01: 2203-2205).

Informants described difficulties in obtaining staff nurse members for the two task forces as an example of a negative signal from the larger body of ***stakeholder members*** that also delayed progression.

Stage 3: Identifying common values. In stage 3 work group members sought to overcome stakeholder differences through the identification of some common values. ***Common values*** were standards for sharing control agreed upon by the work group. Three types of common values were identified from informant comments and council/committee minutes: ***core, relational, and functional***. ***Core values*** were values considered by work group members as central to the concept of shared governance in the study hospital. Valuing expertise rather than scalar position as the basis for involvement in decision-making was an example of a core value. As described in Structure Task Force minutes (July 26, 1991), "those making the decision have the knowledge base re the decision" (p. 4). ***Relational values*** were values that defined acceptable behaviour in or by the work group making the changes. Exercising control in a "collaborative" versus autocratic manner was a relational value present throughout the study period. ***Functional values*** were values intended to ensure that the desired changes in sharing control resulted in a model that was workable in the study hospital. Examples of functional values for the New Model identified by informants were that the model fit the organization, be affordable, and ensure communication.

Stage 4: Making a blueprint. In stage 4 work group members developed a plan for altering structures, roles, and decision-making processes in the governance model to fit with the core and functional values identified in stage 3. A key property of this stage was a focus on ***redesigning*** that varied in intensity from ***renovating to building***. In ***renovating***, work group members developed a plan to alter the existing governance model. Clarifying the role of Old model council members was an example of renovating. Members were to communicate and represent the views of their constituent group (Old Model minutes, April 19, 1991, p. 1). ***Building*** involved work group efforts to develop a new approach to sharing control that involved replacing the existing model. As described by informants, building meant "starting afresh", putting aside the problems of the past, "creating". Designing the New Model was an example of building.

Stage 5: Establishing the changes. In the fifth and final stage work group members used various strategies to implement the plan developed in Stage 4. ***Strategies*** employed included obtaining formal approval, scheduling, educating, formalizing, and aligning. Formalizing referred to documentation to ensure that the core and functional values inherent in the redesigning decisions of Stage 4, remained intact. Development of generic council terms of reference and role definitions were two examples of formalizing related to the New Model. Aligning referred to activities aimed at accommodating the New Model in the Study Hospital. Successful completion of this stage resulted in the establishment of a ***different state of sharing control*** in the governance model.

Movement Through The Stages

Figure 1 is a schematic representation of the five stage process identified. The use of discontinuous lines to define the stages reflects the intricately connected nature of the process. Though progression occurred sequentially, completion of the process of ***Making Changes*** required that the work of previous stages continue into the last stage. Completion therefore depended upon appropriate problem identification, sustained commitment to change, maintenance of common values, formation of a workable plan, and successful use of implementation strategies. An inability to sustain the work of earlier stages prompted regression, that delayed or stopped progress. In Figure 1, upward movement from the current state at (CS) to a different state at (DS) represented changes in sharing control arising from completion of the five stages.

Figure 1 represents one complete cycle of the process of ***Making Changes***. Over the study period several cycles

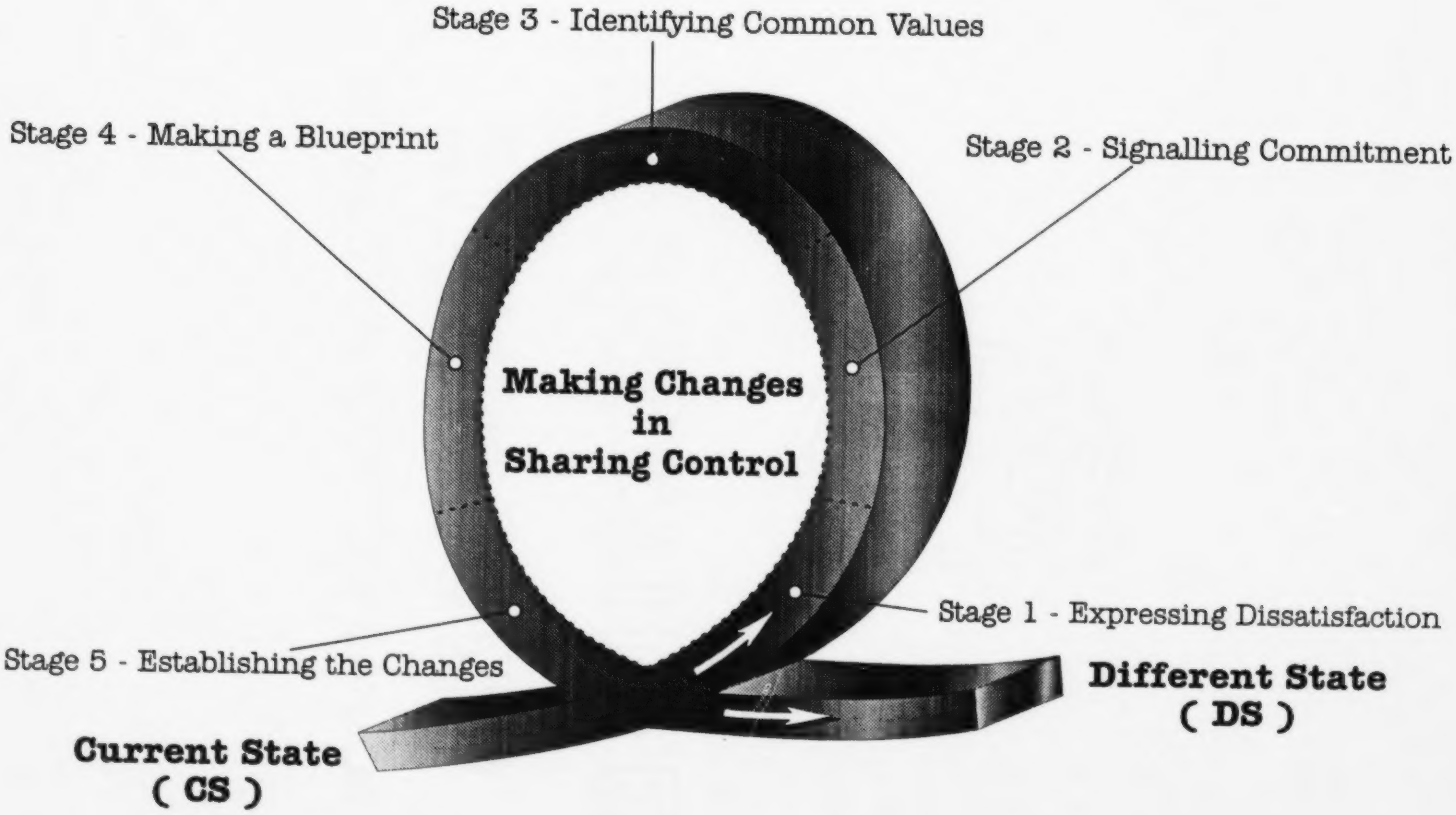

Stage 3 - Identifying Common Values
Stage 4 - Making a Blueprint
Stage 2 - Signalling Commitment
Making Changes in Sharing Control
Stage 1 - Expressing Dissatisfaction
Stage 5 - Establishing the Changes
Different State (DS)
Current State (CS)

Figure 1. Five stages in the process of ***Making Changes in Sharing Control.***

of this five stage process produced changes in the sharing of control. Definition and description of these cycles follows.

Five Cycles of *Making Changes*

A cycle was a repetition of the five stages occurring in a particular period and involving a unique work group. As seen in Figure 2, five cycles occurred over the study period. To avoid confusion with the stages, alphabetical labels identify the cycles. In Cycle A, Old Model Council members renovated the Old Model and approved plans to build a new model. In Cycle B, the Nursing Union, VPN, and Hospital President identified a need to build a new model of shared governance. In Cycle C, the Structure Task Force designed and implemented a new structure for shared governance and in Cycle D, the Decision Task Force attempted to define how decision-making would occur in the new structure. Cycle E was an incomplete cycle that involved efforts by New Model Council members and a reconvened Decision Task Force to deal with the New Model's structural and decision-making problems. In the following discussion the researcher demonstrates how the five stage process applies to each cycle and provides cycle specific examples and explanations of each stage's main properties.

Cyclical Variations Defined

Cycle A: Renovating the old model. In stage 1, Expressing Dissatisfaction, *issues* focussed on the

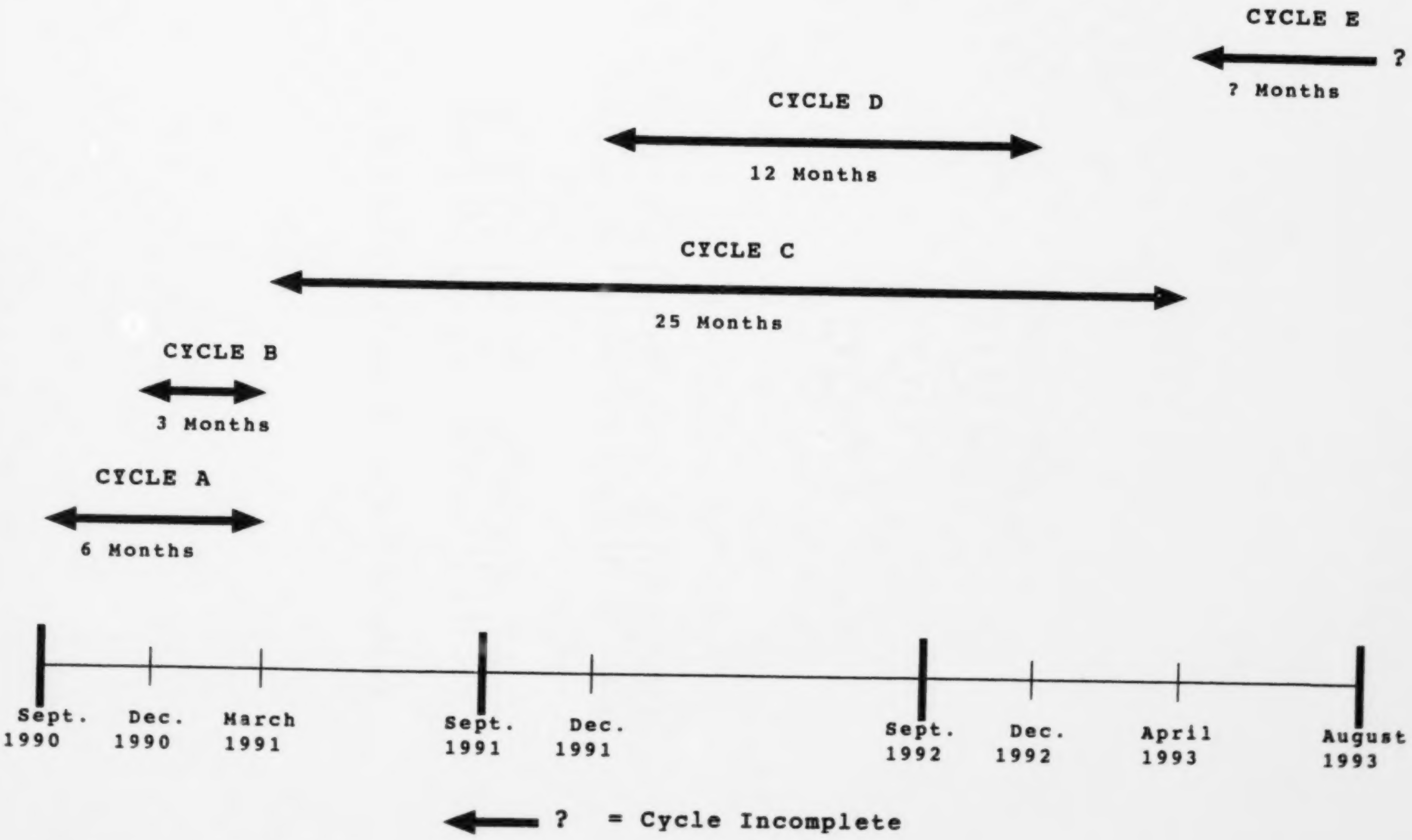


Figure 2. A time line of five cycles of *Making Changes* occurring during study period.

sharing of control by the VPN/Nursing Directors. Staff nurses, union officials, and nurse manager representatives at the Old Model Council indicated disapproval of the centralized and autocratic approach to communication and to decision-making used by the VPN/Nursing Directors during an economic crisis. As recorded in the minutes of the Old Model Council (September 5, 1990), managers complained that

> they were uninformed on many of the changes and so were unable to inform nursing staff, but were perceived to be holding information back (p. 4),

while staff nurses reported feeling distressed and uneasy, "re the number of rumours and lack of hard data" (p. 4). Council members were not placated by the suggestion from one nursing administration member that because

> the corporate division does not practice Shared Governance, it was not possible to apply the principles of shared governance to all decisions that needed to be made (Old Model Minutes, September 5, 1990, p. 4).

Members emphasized the importance of "facilitat[ing] communication and input gathering [even during emergency decision-making]" (p. 4).

Besides poor communication, the ***main problem*** agreed upon by council members in cycle A was generalized confusion among the stakeholder groups about who had control over what decisions. As one informant said,

> we had never identified any limitations or boundaries in terms of decision-making and so we fell into either . . . managers feeling that they could give away every decision . . . or the staff expecting that every decision would be theirs and then a manager would make a decision and the staff would say, "Oh, I knew she didn't believe in shared governance" (I01-01: 1019-1032).

Another informant noted that,

> It wasn't clearly defined even for the management level where they were authorized or [had] consent to go ahead (BIO-09-01: 201-204).

Evidence of movement into the second stage of **Signalling Commitment** was noted in council members scheduling and giving priority to attendance at an "emergency meeting" (Old Model Council minutes, September 5, 1990, p. 2) to discuss further the problems with sharing control. Another example of a ***positive signal of commitment***, early in this stage, was a Council decision to make the "replacement of staff for meetings and other structures of the shared governance system" (Old Model Council minutes, October 3, 1990, p. 2) a number one priority in government funding requests. Examples of ***positive signals*** occurring during a return to this stage, late in the cycle period, included a decision by three staff nurses to continue their attendance despite an "urging" to withdraw by the Nursing Union and a decision by Old Model council members that the activities of the Council would continue without the union.

In the third stage of **Identifying Common Values**, task force members reaffirmed communication, sharing, and respect as three ***"core values"*** of shared governance (Old Model Council Minutes, September 13, 1990, p. 3). Ensuring communication was an example of a ***functional value*** arising out of the problems with communication initiating this cycle. A brief return to this stage occurred when the

Nursing Union returned to the Old Model Council at the end of the cycle period. ***Relational values*** or "ground rules" to guide work group behaviour reaffirmed by the complete Council mirrored core values. Besides respect, participants were to support equal and active participation, and to foster open communication by being objective and non-judgemental (Old Model minutes, March 6, 1991, p. 1).

The fourth stage of **Making a Blueprint** focussed on renovating. Examples of ***renovating*** were structural change and role clarification aimed at resolving the communication problem and supported by the core value of sharing (collaboration). The nursing division was divided into eight areas, followed by peer election of staff nurses to represent their constituent group at council meetings. Staff nurses from all areas of the nursing division were therefore represented in council membership.

Strategies used to **Establish the Changes** in sharing control included obtaining formal approval from the Old Model Council for structural changes and scheduling the electoral process. This cycle ended with a decision by the Council to form the Structure Task Force to deal with unresolved problems with the sharing of control. The main ***change in sharing control*** resulting from this cycle was the move toward a democratic way of exercising control by staff nurses.

Cycle B: Committing to a new model. Cycle B began part way through Cycle A when Nursing Union representatives at the Old Model Council took *issue* with the sharing of control in the governance model and with actions by the Corporate Division and by the VPN/Nursing Administration. Dissatisfaction with the Old Model focussed on the centralization of control and on the tendency of some managers to hold onto control. Union officials suggested, for example, that staff nurses felt disempowered by a role perceived as "rubberstamping" and wanted more involvement in the total process of decision-making (Old Model minutes, December 12, 1990). Union officials also suggested that

> some decisions will never be made by staff nurses, even though staff nurses were to have made them . . . [because] managers [still believe] that staff are not responsible to make decisions (Old Model council minutes, December 12, 1990, p. 8).

Examples of dissatisfaction at the corporate level appeared to focus on a perception that "the core values are not believed" (Old Model Council Minutes, December 12, 1990, p. 9). As another Union official said,

> Nurses should have been named to each and every committee that makes decisions involving the institution, not pick and choose what committees nurses might participate in . . . (Old Model Council Minutes, December 12, 1990, p. 1).

The Union's response to an administrative attempt to involve the Old Model Council in economic decisions, exemplified the Union's dissatisfaction with inappropriate actions by the VPN/Nursing Directors. As one informant recalled, the Union was adamant that such discussions had implications for the ongoing tenure of staff nurses and were therefore,

> totally out of the jurisdiction of [the Old Model Council]. This is a labour relations and collective agreement and a management issue and should not be discussed here (I01-02: 150-155).

During a return to the stage of **Expressing Dissatisfaction**, three ***problems*** were identified for resolution: effective communication; the structure of/for decision-making in the Nursing Division; and "recognition of the [name of Union] as the representative of nurses" (Administration/Union Ad Hoc Committee minutes, February 20, 1991, p. 2).

A ***negative signal*** of commitment, evident in the Union's decision to withdraw from all activities of the Old Model Council, was the first indication of movement into the second stage of **Signalling Commitment**. Although this action initially delayed progress in ***Making Changes***, a later ***positive signal*** supported forward movement. A new group composed of the Hospital President, the VPN, and the Nursing Union was formed to "table matters of mutual interest" and to provide a forum for resolution of issues interfering with "harmonious relationships between the parties" (Administration/Union Ad Hoc Committee minutes, February 20, 1991, p. 1).

In the next stage of **Identifying Common Values** the Study Hospital and Union reaffirmed that ***core "vision and values"*** were

> in accord regarding employees having authority and

> accountability for decision-making in their jobs [expertise-based control] and [regarding] the presence of effective partnerships [collaboration] between the Hospital, its' employees, and the employee's representatives (Administration/Union Ad Hoc Committee minutes, February 20, 1991, p. 2),

Recognition of this common value base supported progression to the fourth stage.

In stage 4, **Making a Blueprint** the work group agreed that the Union would return to the Old Model Council and that the council as "re-established" would delineate and decide "upon a new structure for shared governance" (Ad Hoc Committee Minutes, February 21, 1991, p. 2). The intended focus was therefore on ***building***. The final stage of **Establishing the Changes** was brief, beginning with the Union's return to the Old Model Council and ending with the council's approval of the presented plan. While some informants viewed the outcome of this cycle as the "failure" of the old model, in the words of one informant,

> What I saw happening was not a demise of the old council, but some very turbulent times [and] a new direction that was set (I04-01: 279-283).

Obtaining formal approval was the only strategy used to establish the plan for change. The major ***change in sharing control*** resulting from this cycle was a commitment to a collaborative way versus a partisan way of exercising control by the Nursing Union and VPN/Nursing Administration.

Cycle C: Building a new structure. In contrast to Cycles A and B, expressing dissatisfaction in Cycle C occurred passively. Unresolved ***problems and issues*** with the sharing of control from Cycles A and B formed the impetus for Cycle C. Movement into the second stage of **Signalling Commitment** occurred with the decision by the Old Model Council to approve the formation of the Structure Task Force to design the new structure. Examples of ***positive signals*** by ***stakeholder members*** included peer support for attendance, and a sense of unity and keenness in the work group. As stated by one staff nurse informant:

> People went without lunch and coffee so that I could go to the meetings . . . it was my [peers] who supported me because they believed in the concept too (I05-01: 1494-1501).

Examples of ***negative signals*** included difficulty in obtaining staff nurses for the task force, and a lack of support by some Nurse Managers and staff nurse peers. Another staff nurse informant described feeling guilty about leaving her patient assignment to attend meetings, because her peers had "a lot of ambivalent feelings about [staff nurses] doing anything outside of [patient care]" (I03-02: 772-775).

In stage 3, **Identifying Common Values**, the Structure Task Force reaffirmed, added to, and elaborated on the values identified previously in cycles A and B. During revision of the Nursing Philosophy (March 1992), for example, members expanded exercising control to include both independent and collaborative actions (p. 1) and added an expectation of a broad range of control. Nurses were to function in "divisional and hospital-wide governance structures at all levels" (p. 2). Task force members also began to specify how control was to be shared in the New Model through the identification of additional *core values*. As recorded in the Structure Task Force minutes (July 26, 1991), task force members wanted:

> All decisions to be made at the lowest level possible/appropriate [decentralized control] . . . ..
> Those making the decision have the knowledge base re the decision [expertise-based versus a position-based source of control].
> Those who have made the decision are accountable and responsible . . . [decision-based versus position-based accountability].
> Consider what each level is being asked to do:
> - give input
> - make recommendations
> - make the decision (p. 4 - 5) [Variation in the degree of control/ decision-making power, acceptable].

A key value regarding who was to have control summarized by one informant was that "this was a staff nurse model . . . [focussed on representing] a staff nurse perspective" (I01-02: 808-818).

Besides reaffirming collaboration as a *relational value* for acceptable behaviour in the work group, in this cycle acceptable behaviour by the work group making the changes was also defined. Task force members were to model the behaviour inherent in the move to shared governance in the new model design process. As one informant said:

> as the birthing committee, we wanted to make sure that we didn't appear dictatorial (I01-01: 602-606).

Examples of additional *functional values* identified in

Cycle C were that the model: fit the organization; fit with the philosophy of nursing and the mission and vision of the greater organization; was adaptable to future change (Model Task Force minutes, May 09, 1991, p. 2); supported efficient decision-making, and was affordable. As one informant recalled, task force members felt that

> if we are going to go through all of this process we wanted it to evolve, . . . we didn't want it to be like the [original] nursing governance . . . that didn't seem to be working (I03-01: 643-650).

In the stage 4, **Making a Blueprint**, ***redesigning*** focussed on building a new structure. Building a new structure consisted of three main activities: (a) defining the councils, (b) defining membership and describing roles, and (c) diagramming or developing a schematic representation of the new structure. The new structure developed consisted of four divisional level councils, a system of unit level councils, and a coordinating committee to ensure communication and coordination (Structure Task Force document, October, 1991). Council membership consisted of elected staff nurses and a management representative, and included a official union representative in each divisional council. Both management and the Nursing Union were to fulfill a resource role in the new structure. As summarized by one informant, management members weren't at councils to make or veto decisions, but rather to "support, inform, [and] facilitate" staff nurses in their new roles as decision-makers and as leaders (I01-01: 377-380; 262-264).

The Union's role, on the other hand, was to protect or to advise. As one informant said,

> they were to constantly be on guard for any decisions . . . [in] conflict with the Collective Agreement (I07-01: 1760-1765).

Another informant said,

> they brought in reminders of the contract . . . and [of] the things we [staff nurses] weren't allowed to touch . . . (I03-02: 239-244).

There is strong evidence of the impact of functional and core values on the redesigning decisions in this cycle. Organizational fit influenced the decision to design a new model rather than to adopt an existing model. As one informant recalled,

> we decided we couldn't fit into any of the particular models . . . we needed something specific to our hospital because we were one of the largest institutions to ever try to put something together like nursing governance and also having a union involved in it (I03-01: 487-498).

The value of ensuring communication influenced decisions about structure. As recalled by another informant,

> We decided that if we were going to solve this communication problem that existed in the former structure that we needed every [unit] council to have some kind of roots into the divisional council, hence the structure where each [unit] council has a rep on all of the divisional councils . . . .. (I04-01: 387-395).

The interaction of three functional values: effective communication, efficient decision-making, and organizational fit, influenced decisions about the organization of the unit council system. An organizational design that grouped the Hospital's 1000 beds into small patient care units meant a large number of units, with 1-3 units per Manager. As one informant recalled:

> When we looked at having a representative from every unit within the nursing division, we realized that the [divisional] council[s] would be just too, too huge and not workable (I03-02: 55-59).

The task force therefore decided that "the smallest denominator for the [unit councils] will be the management area associated with one nurse manager" (Proposed New Model, Structure Task Force, October 1991, p.2).

Collaboration was a core value that influenced decisions about membership and decision-making in the new structure. As well as supporting the presence of a management and union representative in the divisional councils, the Structure Task Force strongly encouraged inclusion in the unit councils of "all members of the health team that have a stake or fulfil a role in [patient care] delivery" (Proposed New Model, Structure Task Force, October 1991, p. 3). Another example of the influence of core values was noted in the decision by task force members to develop a structure that was "generic . . . , [that provided] a basis, a starting point of where we thought the model should go . . . " (I03-02: 184-186; 194-195). Consistent with the values of collaboration and decentralized control, the intent was that staff directly involved in the operating model would further define and refine the model. A final example of core value influence was evident in a decision by the Structure Task Force to support consensus rather than majority vote decision-making in the task force and in the new structure. As described by informants decision-making by vote was seen as dividing participants into "winners and losers", while consensus was consistent with a more "unified" approach. As one informant explained, consensus decision-making,

> didn't mean that everybody had to agree in the group . . . so long as [the decision] was something the group as a whole could accept . . . [and] live with (I08-02: 1081-1085, 1101-1102).

Use of ***strategies*** **to Establish the Changes** in Cycle C was extensive. In addition to obtaining formal approval from the Old Model Council and to scheduling a staged implementation of the New Model Councils, three new strategies appeared: educating, formalizing, and aligning. Educating and preparing staff for the changes in sharing control consisted of orientating staff to the new structure, to new values, and to new skills. In the words of one informant, orientation efforts in the nursing division were "massive" (I07-01: 391) and included presentation of "over 100 inservices" to staff nurses on all shifts, publication of the new structure in the nursing division newspaper, and an in-depth half-day seminar for all managers and a staff nurse unit representative. Orientation of the Hospital Board, Medical staff organization, and nursing staff to the nursing division's new values begun in stage 3, was completed in this stage. Attention to skill development included a "strong recommendation" by the task force that council members have an opportunity to attend classes on group problem solving (Guidelines for Implementation of Divisional Councils, Model Task Force, March 1992). Formalizing efforts included development of generic terms of reference and council implementation guidelines and of role definitions of model participants ranging from secretaries to facilitators. In formalizing, members were attempting to ensure that the core and functional values underlying the model's creation remained intact.

Aligning was a strategy unique to Cycle C. Internal alignment referred to the need to integrate the old model for sharing control with the new model. Integration occurred by absorbing relevant committees through the use of transitional arrangements intended "to ensure that the work [of the old committees] continued" (I10-01: 1012-1014), and that the expertise and knowledge of previous committee members was not lost. Recognition of limited staff experience with committee work also prompted transitional arrangements. As two informants said, the task force recognized that "this was a whole new experience" (I01-01: 393-394) for the majority of staff nurses, and that staff needed time to get to know one another, and to learn "how to do what they were supposed to do" (I10-01: 1017-1018). When the new model was initiated directors therefore acted as temporary divisional chairpersons.

Internal alignment also included adjustments in the sharing of control between and within the operating councils of the New Model. Divisional councils amended generic terms of reference, reassessed assigned committees, finalized membership, identified committee gaps and council overlap, and began to seek readjustment. Alignment within each council focussed on determining the decision-making power of the council's various committees. Some councils "agreed that the subcommittees refer recommendations to council for discussion/approval" (New Model Practice Council, January 05, 1993, p.3). In others, committees made procedural decisions and as described by one informant (I02-01) used the larger council for "setting policies" (855).

External alignment referred to the new governance model's linkage with existing hospital departments/committees and with external professional bodies. Such linkages were used to share information, to access needed resources, and to represent the interests of nursing in decision-making as committee members.

The end point of this cycle was less clear than that of Cycles A and B. Though implementation of the final divisional council occurred in January 1993, alignment was still happening when a resurfacing of problems and issues initiated another cycle of change, Cycle E.

Changes in sharing control arising in earlier cycles were reaffirmed and added to in this cycle. The change to a democratic way of exercising control in the staff nurse group continued in the New Model. The commitment to collaboration though still present, was less important than staff nurses having control over decisions made in the governance model. As one informant said,

> the people [who] were kind of left out of this whole thing were the managers and I believe we probably did that consciously to prove to staff that this is not a management process (I01-01: 1415-1423).

A new change was the development of a model with decentralized and centralized components. Though participants recognized the need for a centralized component to deal with matters impacting the whole nursing division, as one informant said,

> We wanted it to be decentralized . . . the [unit] councils [were to] have all the say in what was going on and if they had problems then they could come to the divisional councils (I03-01: 1104-1109).

Cycle D: Defining decision-making. Cycle D began in the midst of Cycle C, shortly after the Structure Task Force had received approval to proceed with implementation of the New Model. In stage 1, **Expressing Dissatisfaction**, dissatisfaction focussed on the proposed governance model. Examples of this dissatisfaction were unresolved *issues*, identified by the Nurse Administrator Group, about the role of the manager and about decision-making in the New Model. There were strong feelings, especially in the Nurse Manager members, that a decision by the Structure Task Force to include managers only in the unit level councils was prejudicial and contrary to the value of collaboration espoused by the task force. As one informant said,

> Empowering seemed to work for certain groups but not for other groups . . . and that frustrated a lot of people (I08-02: 516-518; 526).

The Nurse Administrator Group's initial concern over the lack of defined boundaries for decision-making was soon identified as a ***problem*** by other stakeholder groups. As one informant recalled,

> one of the things that kept coming up in some of the inservices was people wanted to know just exactly what kind of decisions can we make? Can we make budget decisions . . . (I07-02: 1132-1137)?

Another informant said,

> We wanted white and we wanted black and we didn't want any grey and that seemed to be the request coming from all levels of nursing (I05-01: 1130-1134).

Another example of dissatisfaction with the new governance model, expressed in a return to the stage of **Expressing Dissatisfaction**, focussed on the role of the Nursing Union. The Nursing Union complained that union representatives should have been included in both divisional and unit councils, to ensure that staff decisions didn't conflict with Union views (Decision Task Force Minutes, December 11, 1992). Management and staff nurses complained that the Nursing Union was inappropriately holding onto control. As recorded in Decision Task Force Minutes, participants asked,

> In management, we are moving away from traditional management structure, is the union also going to move from the traditional union (p. 2)?
>
> Are we dividing staff nurses and the [Union] as the new we-they? As members of the [union on unit councils] are we not saying the same thing as the Union (p. 3)?

Similar to previous cycles, the ***main problem*** agreed upon by members of the Old Model Council and the Structure Task Force was generalized confusion among the stakeholder groups about who had control over what decisions.

The Old Model Council and the Structure Task Force ***positively*** **signalled their commitment** by approving the formation of the Decision Task force to "define decision-making guidelines and to reach consensus" (I01-01: 1052-1060) regarding appropriate areas for staff nurse involvement. Similar to that identified in Cycle C, ***negative signals*** from members of stakeholder groups included difficulty in recruiting staff nurse members for the task force.

In Cycle D **Identifying Common Values** was both a passive and active activity. The ***core values*** identified in cycles A - C formed the basis for this cycle. Task force members therefore did not actively engage in identification, rather core values were implicit. Clearly defined boundaries for staff decision-making was the main ***functional value*** identified. In identifying ground rules to guide group behaviour the task force reinforced the ***relational value*** of collaboration. As one informant said,

> We were there to make this work . . . If we weren't going to be able to speak straight with one another then we weren't going to get anywhere (I09-01: 590-594).

Similar to Cycle C, in stage 4, **Making a Blueprint**, task force efforts focussed on ***building***. Members developed a decision-making schematic/model of "about 28 questions that you should always ask when you go to make a decision" (I01-01: 1069-1071) and a limitations document (October, 1992) that "highlight[ed] examples of decisions made outside of [unit] councils" (p. 1). The task force also identified the group/individual responsible for making the final decision and indicated how or if staff could contribute in the decision-making process. The VPN initiated plans to clarify decision-making by introducing all management in the nursing division to a concept called levels of authority. The concept provided "a framework to describe involvement in decision-making" (I04-01: 521-522), applied within the context of varying levels of staff maturity and readiness for involvement.

In **Establishing the Changes**, members of the task force used two *strategies*: obtaining formal approval and formalizing. Following approval from the Old Model Council and from the Structure Task Force, distribution of the decision model and limitations documents to all the nursing units occurred. Educating was the dominant strategy used by the VPN to help managers understand their new role. Education to incorporate the levels of authority concept at the staff level became part of the facilitating role of directors/managers at the divisional/unit councils. This cycle ended with the disbanding of the Decision-Task Force and with completion of management education on the levels of authority concept.

Changes in sharing control in Cycle D focussed on identifying specific areas for staff nurse involvement and on defining the associated degree of control or decision-making power. As indicated in the limitations document (October 1992), staff councils were to have final decision-making in areas of nursing practice and to work with managers in making unit-related resource decisions. In corporate decision-making, however, the role of staff councils was to recommend or give input. As well, though staff councils could make decisions within the confines of the collective agreement, the Nursing Union would remain as keeper of the contract. Support for a source of control based on expertise and not on scalar position was evident in acceptance of the levels of authority concept. As one informant explained,

> A level of authority isn't allocated because of who you are or what your position is . . . it's that particular issue and your background and experience (I01-02: 2044-2062).

Cycle E: Renovating the new model. In Stage 1: Expressing Dissatisfaction, *problems and issues* identified by members at council meetings focussed on the sharing of control in the New Governance Model and by the VPN/Nursing Administration. *Problems* with the New Model's divisional councils included: council representatives not representing the views of their peers; "turf wars" between the councils over the placement of issues and over the alignment of Old Model Committees; lack of a common forum to address issues of interest to two or more councils; and duplication of effort in the councils. As one informant said,

> Within the hospital people did not know which council to send requests for a decision to, so they ended up sending [the issue] to all four [divisional] councils (I02-01: 194-199).

The *issue* of nurse manager involvement in divisional councils resurfaced in this cycle. New Model members were asked to consider a recommendation from the Nurse Manager Group that the group "function in a similar fashion to the [Unit] Councils and have one representative to each of the four [divisional] councils" (Letter from the Chairperson of the Nurse Manager Group, April 5, 1993).

An example of management inappropriately exercising control was noted in use of the levels of authority concept. As one informant said,

> Managers and directors were using [the levels of authority concept] as a control . . . We have never been past level 1 [i.e. data collection only] . . . This is a decision-making model and you are not letting us make decisions (I05-01: 1155-1163).

Another informant said,

> There was a council who in their agenda would have items identified and beside it a level of authority [would be assigned]. . . . To me, that's a major misuse of levels of authority because (a) there's no negotiation, and (b) right away it is management in control (I01-02: 2524-2532).

Positive* signals of commitment** from the divisional council members that began to move the process of ***Making Changes forward were a reconvening of the

Decision-Task Force to deal with inappropriate use of the levels of authority concept and the formation of a small group from all the divisional councils to deal with governance model problems. **Identifying Common Values** in this cycle was mainly a passive activity. ***Core values*** were passed on in documentation and through education sessions arising from Cycle C. Evidence of implicit values was seen in the request for inclusion as a unit council made by the Nurse Manager group. Inclusion was requested in keeping "with the aim of partnership and increased communication in the evolution of our shared governance model" (Letter from the Chairperson of the Nurse Manager Group, April 5, 1993). Work group ***relational*** values also originated from Cycle C. When divisional councils were forming, members had reviewed and revised a common set of ground rules. Affordability was a major ***functional value*** identified by all informants due to an economic crisis occurring in this final cycle of ***Making Changes***.

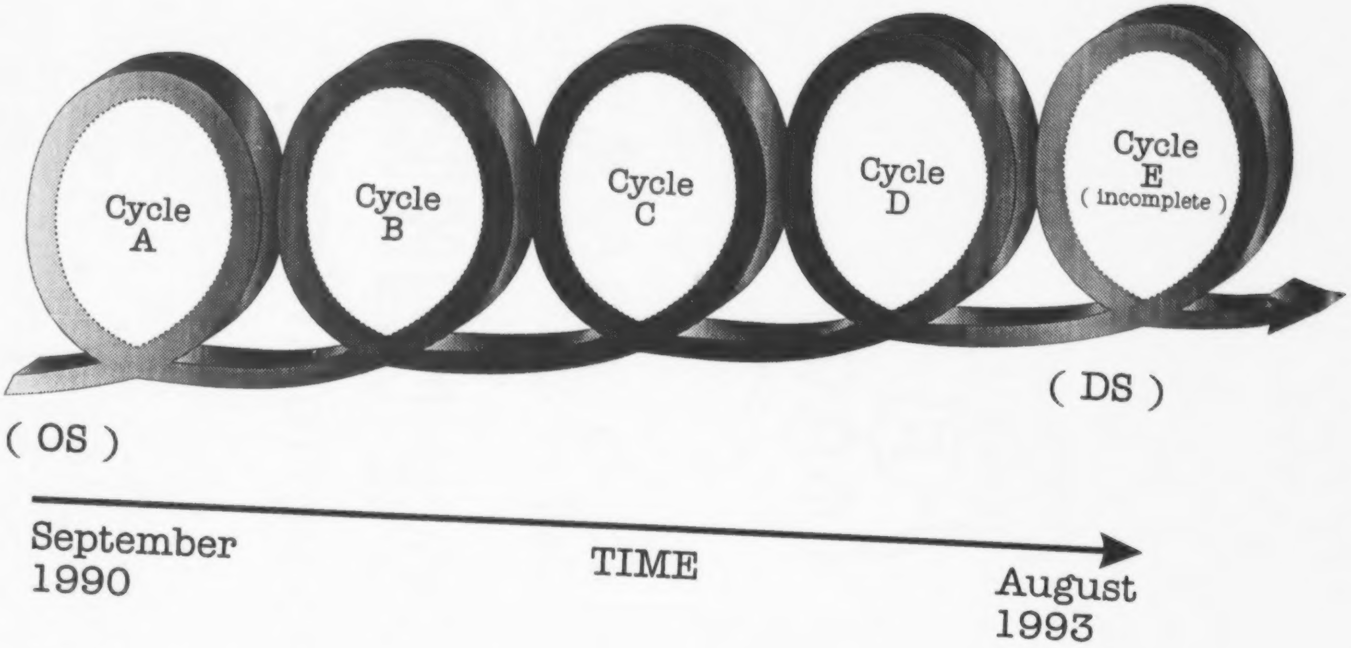
The economic crisis that arose during this cycle had a significant impact on progression. Return to earlier stages was common and work aimed at **Making a Blueprint** was finally halted due to a decision by New Model Council members to place a hold on all governance activities until all restructuring activities were complete.

The Evolutionary Nature of *Making Changes*

As described by informants and as recorded in council minutes, the process of developing the shared governance model was "an ongoing evolutionary type of thing" (BIO-10-01: 193-193); "a growing process. . . a five year plan" (Old Model minutes, December 12, 1990, p. 6). Figure 3 is a simplified representation of the cyclical process of ***Making Changes*** that occurred at the study hospital. As demonstrated in previous discussion, completion of each cycle resulted in small changes in how control was shared that were reaffirmed, added to, or elaborated on in later cycles. In Figure 3, upward movement from the original state at (OS) to a different state at (DS) represented changes in the state of sharing control during the study period. Over the three year period, participants moved from a governance model that was centralized and autocratic, with limited staff involvement and having a high propensity for control by management; to a model with both centralized and decentralized components, with widespread staff involvement in councils dominated by staff nurse members, and with a potential for control favouring staff nurses.

Influencing Factors

The third research question was to identify salient factors influencing the development of shared governance. There were four major factors that influenced movement through the process of ***Making Changes*** as well as


Cycle A
Cycle B
Cycle C
Cycle D
Cycle E (incomplete)
(OS)
(DS)
September 1990
TIME
August 1993

(OS) = original state of sharing control; the state preceding cycle A.
(DS) = different state of sharing control; the state at the end of cycle D.

Figure 3. Cyclical repetitions of the five stage process of **Making Changes,** producing gradual and ongoing changes in the sharing of control.

choices made at different stages in the process: the economic climate; stakeholder values and beliefs; the nature of stakeholder relationships; and the actions of the VPN. In terms of movement, the four factors if functioning constructively, facilitated progression, but if functioning ineffectively constrained or delayed progression.

The Economic Climate

Two periods of ***economic instability*** had both a facilitating and constraining impact. The first period began prior to Cycle A and ended just before the conclusion of Cycles A and B. The second period began midway through Cycle C, just as Structure Task Force members were preparing to implement the New Model, and reached crisis proportions in Cycle E. These periods of instability facilitated progression by raising the level of dissatisfaction such that stakeholder groups sought to express formally their concerns. In cycles A, B, and E, the periods created an air of uncertainty that infused stakeholder relationships with mistrust and that prompted nurses at all levels to question the reality of the shared governance process at the study hospital. A return to more familiar and safer ways of exercising control by the corporate division and by nursing administration during these periods, escalated these feelings of mistrust and dissatisfaction. As one informant explained,

> Well, and I'm not sure under times of stress that there isn't a reverting to the old model too. Like none of us

> is perfect in practicing this whole new scene and so I think there are probably some very legitimate concerns being raised where decisions are being taken without even seeking input . . . particularly in times of crisis I think that tends to happen (I04-01: 1667-1680).

The mistrust arising from the periods of economic instability also acted as a major constraining influence. Mistrust supported the generation of negative signals of commitment that delayed progression through or prompted a return to stage 2, **Signalling Commitment**. Abstention from participation in the Old Model Council by Union officials was a negative signal of commitment arising in cycle B, while in cycles C - E such signals focussed on a reluctance in staff nurses to commit to membership in the various task forces and new model councils. Additional negative signals arising from the economic crisis in cycle E significantly slowed progression: loss of financial support for the model and staff apathy. As one informant said,

> People really would rather have a job than care about nursing governance and that's basically the bottom line right now (I03-01: 2188-2194).

In terms of choices, the need for fiscal constraint influenced a decision about one "hot issue" in cycle C - payment for staff attendance at the new model's divisional and unit councils. Though many Model Task Force members, and in particular staff nurses, were adamant that "if you weren't going to pay staff nurses to come to meetings, they won't come" (I03-01: 1245-1247), the final decision was to pay only for divisional council attendance.

Stakeholder Values and Beliefs

Congruency in basic values and beliefs about the sharing of control facilitated progression through most stages of ***Making Changes***. Congruency supported positive signals of commitment and facilitated work group efforts to identify common values, to plan, and to establish changes in how control was shared. According to one informant (I10-01), the Union's decision to return to the Old Model Council at the end of cycle B and the ability of task force members in cycle C to strike a "common ground on which to develop the [new] governance model" (1299-1300) was made possible because of the Union's

> strong belief in the concept of the profession of nursing and [in] the ability of nurses to make decisions that are relevant to their practice (1272-1276).

Congruency also influenced the commitment of individuals. One management informant got involved in the various task forces/councils because

> I've always been a believer in what we used to call participatory management so to me this was just giving my own beliefs credence. . . . (BIO-01-01: 8-12).

A staff nurse got involved because

> I believe in respect and [under] the old concept, the hierarchy scale, there was no respect. . . . People played games and power was knowledge and it resulted in . . . frustration for the working nurse (BIO-05-01: 215-220).

The particular beliefs and values of individual managers also influenced establishing in cycle C. As one informant explained, some managers

> weren't receptive [to the new model] because this was not their style . . . and I think some of them found it very hard to change. . . . Unit managers who had always been running this way were really happy about it (I05-01: 681-682; 673-675).

Incongruency in stakeholder values and beliefs potentiated conflict that slowed or stopped progression or that prompted regression to an earlier stage. In cycles C and D informants talked about spending a lot of time in the planning stage, "negotiating back and forth". As described by one informant, negotiations focussed on control changes in "thorny or hot" areas, that is, areas "traditionally a management right . . . [or] a union issue" (I01-01; 1621-1623). In cycle E different beliefs in Nursing Administration and in the Nursing Union about the role of staff nurses in economic decisions, prompted a return to the stage of **Expressing Dissatisfaction**. One informant summed up the situation at the end of the study period:

> We are coming to the conclusion that the union has a particular role on behalf of their members that is in conflict with the role we [administration] are expecting staff to play as a participant in decision-making. . . . We are really wanting to work with our staff . . . not as union members but as professional care givers (I04-01: 105-110; 1419-1425).

In spite of a belief in professional practice, complete commitment by the Nursing Union to making changes in sharing control was constrained by the threat of developing incongruency in the Union group. As one informant explained,

> when it comes to things like partnerships and shared decision-making, there are obviously great threats there for unions because in essence it is empowering the people and if you empower the people pretty soon they don't need somebody else to get involved on their behalf

> . . . (I01-01: 890-902).

In terms of choices, in all cycles of ***making changes*** the Union consistently and strongly resisted any changes in sharing control by Nursing Administration or by individual staff nurses/units that had the potential to infringe on areas within the Union's jurisdiction.

The Nature of Stakeholder Relationships

Positive relationships characterized by trust, respect, and open communication led to positive signals of commitment that sustained progression through subsequent stages. One informant in speaking about the relationship between management and the Nursing Union that developed in cycle C suggested that:

> They've bought into this process as equal partners. We couldn't have done it without them. . . . We still battle over things and we are still involved in grievance processes . . . but in between those things we're able to work together . . . and come out with positive outcomes that we can both buy into (I01-01: 976-992).

Another informant spoke of management and staff relationships:

> This was the first meeting that I had ever been at that it was okay . . . [for] a staff nurse [to] openly challenge a DON [Director of Nursing] or even . . . the VP Nursing. It became very obvious that that was perfectly acceptable . . . things started to pick up after that because then I realized that we were going to be taken seriously (I07-01: 80-84; 93-95).

Negative relationships characterized by mistrust produced negative signals of commitment that delayed progression. Union officials abstained from participation in cycle B, because it was "unsafe for [Union] representatives to participate: decisions and discussions are being used against us" (Old Model Council, December 12, 1990, p. 1), while staff nurses delayed commitment in cycles C and D because, as one informant stated,

> they didn't believe they were honestly going to get to make any decisions, that this is just something to pacify us . . . We are just going to be rubberstamping (I07-01: 522-525; 529-530).

Previous relationships between managers and staff created particular difficulties with establishing in cycle C. As one informant observed:

> [Staff] whose managers were the old dictatorial side . . . interpreted [the model as meaning] we'll make the decisions and we are going to tell you [what to do] . . . the ones that had been used to a manager that would communicate and consult didn't [react like that] (I05-01: 992-996; 982-991).

In Cycle C, *negative relationships* had a major influence on decisions about structures and roles. One informant (I08-01) suggested that the presence of mistrust influenced the decision to have a resource council dominated by staff nurses:

> There had been layoffs in 1990 and the nurses [and the Union] felt that if the whole system was to have any credibility they had to have a resource council where nurses could be seen making significant and not just icing-on-the-cake decisions . . . (I08-01: 291-302).

One management informant suggested, and a staff nurse informant agreed, that the decision to include managers only as members of unit level councils arose in part from

> that old trust-mistrust and fear that once a manager gets in here, she'll just start making decisions (I01-02: 980-983).

According to another informant, mistrust also influenced the strong emphasis on a facilitating versus decision-making role for management in the new model:

> Because of [shared governance's] history and . . . the amount of resentment, there was . . . almost a bending over backwards to make sure you didn't allow . . . management per se any power in the model (I08-02: 687-694).

Problems with exclusion due to lack of trust continued as participants attempted to establish the model. One informant reported that

> in some units [nurse managers] were not seen as voting members . . . and there were some [units] that did not even want their manager in the group (I09-01: 1195-1201)!

Avoidance of decisions in controversial areas due to past mistrust was also described. As one informant said,

> The decisions that didn't get made probably related to the fact that we didn't want to get into complete disagreement at the [Model Task Force] meeting (I08-02: 720-723).

The Actions of the VPN

Support by the VPN had the general effect of facilitating progression through the process of ***Making Changes***. This became particularly evident in Cycle E when organizational restructuring resulted in elimination of this position. As one staff nurse said, for the model to continue, "there's going to have to be someone at the top willing to do something with it" (I03-01: 2210-2215). In terms of specific effect, support of the VPN had a significant impact on the particular changes made in stage 4, **Making a Blueprint** and on promoting acceptance of the changes in stage 5, **Establishing the Changes**. The VPN influenced choices made in stage 4 in all complete cycles. In cycle A the VPN supported a plan to continue with the governance model without the Nursing Union; in cycle B the VPN was a key member of the group that initially supported a plan to develop a new model; and in cycle D, it was the VPN who introduced the levels of authority concept. The most extensive impact, however, occurred during building in cycle C. Though one informant suggested that "the VP of Nursing participated . . . as an equal member of the group [the Structure Task Force]" (I04-01: 1166-1169), other informants perceived that at times the VPN used her positional power to influence the developing model. One informant suggested that issues and problems that the task force had already resolved would resurface because:

> It appeared that in particular, the VP did not like the decision that was made and therefore it came back to the table (I01-03: 4248-4251).

Another informant suggested that the VPN limited staff control by making major renovations to an educational document on the new model developed by two staff nurses. As this informant recalled,

> The flavour was different after it was rewritten . . . Some of the answers were softened so that they didn't give the [staff] nurses as much power as originally [suggested] (I07-01: 862-864; 873-875).

Informants also suggested that the VPN placed constraints on management input. As one informant said,

> The management people (in the Structure Task Force) had been told very clearly that this model was going to work . . . it was something staff needed . . . so you had issues in real life that were going to cause problems that were never finished off or never sent to the group (I08-02: 725-729; 734-737).

VPN support for the governance model enforced with resistant managers both facilitated and constrained completion of the stage of **Establishing the Changes** in cycle C and subsequent cycles. A staff nurse positively recalled one manager being told by the VPN, that "this model [New Model] was going through whether she liked it or not" (I05-01: 671-672). According to some management informants, however, such actions coupled with the VPN's insistence on a staff dominated governance model, prompted feelings of exclusion and powerlessness in the Nurse Manager Group that led to a lack of enthusiasm for the model. As one informant summarized:

> It was always what does the staff nurse believe and what does the Union believe. . . . It really wasn't important what the manager thought (I09-01: 1156-1160).

Summary

In this chapter the researcher identified and described the core process, ***Making Changes in Sharing Control*** that summed up the essence of what was going on during the development of shared governance in the study hospital. ***Making Changes*** was the core social psychological process through which groups of stakeholder representatives transformed stakeholder concerns about the sharing of control into structural changes such that a different state of sharing control resulted. The process consisted of five consecutive stages each representing a distinct action related to the sharing of control engaged in by participants. Over the three year study period four complete cycles of this process impacted by four major factors, produced subtle changes in how control was shared at the study hospital.

The next chapter concludes the thesis and contains propositional statements arising from the study and a discussion of key findings in the context of current literature and research.

CHAPTER V

DISCUSSION

In this chapter discussion includes a review of how the study findings relate to current literature, identification of propositional statements arising from the research, and a summary of study implications, strengths and limitations.

The Findings and Current Literature

Using grounded theory, the researcher identified a core process, ***Making Changes in Sharing Control***, as central to the development of shared governance in the study hospital. As indicated in Chapter IV, it was the involvement of stakeholder representatives in cyclical repetitions of a five stage process that produced subtle changes in the nursing division's sharing of control.

The Process as a Series of Stages

The use of stages to depict the process of developing a shared governance model is not unique. Several authors have described the developmental process as a series of steps (Deremo, 1989, 1990; Jenkins, 1991; Peterson & Allen, 1986a) or phases (Smith, 1992). Others have applied the steps or stages of a pre-existing theory such as Lewin's change theory (1951) (see for example, Caramanica & Rosenbecker, 1991; Houston & Green, 1993; Perry & Code, 1991; Twite et al., 1993) or Ferguson's paradigm shifting (1980) (see for example, Pinkerton et al., 1989) in an attempt to describe their implementation experience. The uniqueness of the model developed in this study is its emergence based on a qualitative analysis of one hospital's three year experience with the development of shared governance.

Support for the Staged Process Identified

The process depicted by Deremo (1989) and Jenkins (1991) lend support to the credibility of the process identified in this research. Steps 1, 2, and 4 of Deremo's process focus on building, a key property of stage 4 **Making a Blueprint**, while steps 3, 5, and 6 focus on implementing, educating, and formalizing, properties of the final stage of **Establishing the Changes**. In addition to correlations with Stages 4 and 5, Jenkin's steps also included creating a common vision, similar to Stage 2 of the process at the study hospital.

Though not identified as a specific stage in any representations of the process, examination of reports of ongoing model development in the literature lend support to the idea of expressing dissatisfaction as the catalyst for ongoing change (Bredeson, 1989; Deremo, 1990; Davis, 1992; Jenkins, 1988; Johnson & Ledbetter, 1993; McMahon, 1992; Pinkerton et al., 1989; Shidler et al., 1989; Twite, et al., 1993). As summarized by Johnson and Ledbetter (1993) in their study on the role of the principal in six schools, it was "critical incidents . . . [that] helped define the course that SDM [shared decision-making] would take" (p. 13).

The process of ***Making Changes*** that emerged is also reminiscent of the social-psychological view of change developed by Lewin (1951). According to Lewin, progression through the change process results from a dynamic balancing of certain driving and restraining forces that act to facilitate/impede the change. In this study, certain factors facilitated or constrained the initiation of new cycles and the ordered stage-to-stage progression occurring within a particular cycle. The five stage process of ***Making Changes*** that emerged also fits with the three stages of change identified by Lewin (1951). 'Unfreezing' the present pattern of behaviour occurred in stages 1 - 3, as dissatisfaction was expressed, as commitment to change was established, and as new values were explored. 'Moving' occurred in stages 3 - 4 with a plan for change arising out of consensually determined values, while 'refreezing' occurred in stage 5 as participants worked to implement the plan identified.

The Unique Nature of the Evolutionary Process

The organizational impact and evolutionary nature of the process identified in this study, is a typical phenomenon reported in the literature. A unique finding of this study concerns the nature of the evolutionary process. Though changes in sharing control in earlier cycles formed the basis for changes in later cycles, development also involved reversion. At the end of cycle A, for example, participants in the Old Model Council chose to revert to an advisory rather than a decision-making role until work by the Structure Task Force could clarify how decision-making should occur (Old Council Minutes, March 6, 1991, p. 2).

The Political Nature of the Process

The process of ***Making Changes*** involved a group process characterized by political behaviour. Dissatisfaction expressed by particular stakeholder groups initiated the process; abstention from participation by some groups halted the process; and progression through the various stages depended upon on consensually derived agreement among stakeholder representatives. An early definition by Cleland (1978) of shared governance as "political model [that] formally and voluntarily recognizes the divergent interest groups having different values" (p. 41) is consistent with the study findings. The political nature of the developmental process was also identified in studies of SDM/SBM by Byrk et al. (1993) and by Chion-Kenney and Hymes (1994). Byrk reported that it was the interaction of three sites of power in the local school council- the principal, teachers, and parents/community members- that resulted in the emergence of a particular type of local school politics, while Chion-Kenney and Hymes concluded that "site-based management is about politics - consensus politics" (p. 24).

The Importance of Identifying Common Values

The stage of **Identifying Common Values** fulfilled two critical functions. First, the exercise of identifying common values created a sense of cohesion and common purpose in the work group, not unlike the stage of 'norming' identified by Tuckman (1965) in his analysis of small group development. Second, successful completion resulted in a common value base for redesigning decisions that facilitated the achievement of consensus in subsequent stages. The importance of common values is recognized in the literature. As stated by Smith (1992) and supported by others (Bondy et al., 1994; Gomberg & Sinesi, 1994; Jenkins, 1991; McDonagh, 1990; Peterson and Allen, 1986a; Peterson et al., 1995; Porter-O'Grady & George, 1996; Walker et al., 1994) the basic values and premises upon which shared governance is founded, form part of a common vision "that sets the direction for development and change [and that] provides the standard to which to aspire" (p. 116). In the study hospital three value standards were identified: core, functional, and relational.

In this study the impact of core and functional values was significant, especially in cycle C when participants were building a new structure. Though informants did not describe any conscious attempt by the various work groups to evaluate potential solutions based on these values, evidence of value influence was noted in the rationale given by informants for specific redesigning decisions. Several instances of value influence were noted in the literature

(Anderson, 1992; Bondy et al., 1994; Deremo, 1989, 1990; Jacoby & Terpstra, 1990; Johnson, 1992; Johnson & Ledbetter, 1993; Sidener, 1995). It was a valuing of individualism in one hospital, for example, that prompted the decision to make unit based governing councils the "crux of our collaborative management system" (Jacoby & Terpstra, 1990, p. 42), while in another hospital, the desire to "promote equality, not subservience" (Johnson, 1992, p. 13) prompted a council membership representative of all staff in the patient care division. A final example of value influence was similar to that experienced at the study hospital. As described by Bondy et al. (1994) a desire to "model the spirit of cooperation and collegiality . . . essential for SDM success" (p. 13) prompted members of one school-based design task force to choose decision-making by consensus rather than by majority vote.

The researcher also found that the dominance of some values in redesigning decisions defined the meaning of other values. In cycle C, for example, the value of "representing a staff nurse perspective" identified by informants defined the meaning of collaboration. Collaboration meant the inclusion of one management and one union representative in a divisional level council dominated by staff nurses.

Facilitating and Constraining Factors

All the factors impacting the process of ***Making Changes*** at the study hospital are also reported in the literature as having a major influence on the ongoing development of shared governance models: support/non-support by upper administration; congruent/incongruent normative values; positive/negative relationships; and a stable/unstable economic climate. In studies in educational settings, several authors suggested that while support at all levels was the ideal situation, it was the strong support of the school principal that sustained the shared governance process (Charles & Karr-Kidwell, 1995; Johnson & Ledbetter, 1993; Lundsford, 1993; Short & Greer, 1989; Sidener, 1995; Smith, 1993). Many authors in the nursing and allied health literature made similar observations. As summarized by Porter-O'Grady (1991a),

> even if the power is not used, most nurses know that [nurse] administrators have the ability to develop participation, define what it is or is not and how it is to be expressed, and create caveats in relation to its management (p. 458).

In the study hospital it was strong support by the incumbent VPN that initiated and sustained the shared governance system.

Though the main impact of incongruency in stakeholder beliefs and values at the study hospital was to delay progression through the process of ***Making Changes***, incongruency had a second effect. It also acted as stimulus for dissatisfaction, and it was dissatisfaction formally expressed that initiated the cycle of change. The potentially beneficial effects of disagreement arising from diverse normative beliefs was also recognized in the literature. As stated in a newsletter of the Center on Organization and Restructuring of Schools (1992), through efforts to resolve such conflict "basic understandings about roles, authority and domains of practice can be recast and the institution itself renormed" (p. 8).

Consistent with study findings participants in educational studies and in McLean's (1995) hospital-based study suggested that the presence of positive relationships characterized by open communication, respect, and trust sustained the shared governance process. Negative relationships had the opposite effect. As stated by Malen and Ogawa (1985) and supported by Smith (1993), fear of reprisal or loss of their job, placed constraints on "teacher identification of issues" (p. 23) and promoted conflict minimization and avoidance.

Environmental factors such as economic climate have a significant impact on the long term survival of a shared governance model. As described by Porter-O'Grady (1991a), "when the hospital or agency has financial, productivity, or medical staff problems that need a 'firmer' style of management participatory systems are often "abandoned - sometimes temporarily, other times for a longer period" (p. 458). This occurred at the study hospital. In addition to administrative reversion occurring in cycles A, B, and E, the impact of an economic crisis at the end of the study period was substantial. The crisis resulted in layoffs and the loss of both governance council members and facilitators, and prompted organizational restructuring that called into question the fit and viability of the current model and that destroyed the model's financial base. Some informants suggested that the resulting loss of funds for council attendance caused participants to question the greater organization's commitment to shared governance and to reconsider their own commitment. In one hospital-based study, McLean (1995) identified the presence/absence of adequate funding to support member attendance at design task force meetings as a facilitating/constraining factor. Reece (1991) and Bondy et al. (1994) also reported disruption in school-based shared governance systems due to economic instability. In these studies, however, it was contractual bumping resulting in the transfer of staff "who may or may not ascribe to the [school] philosophy" (Reece, 1991, p. 23), that caused school staff concern over the model's continuance.

Propositional Statements

Propositional statements derived from the findings of this study on the development of a shared governance model are:

1. Development of a shared governance model in a nursing division focuses on making changes in sharing control.
2. The developmental process consists of cyclical

repetitions of progression through consecutive stages, resulting in the emergence of a different state of sharing control.

3. Development of a shared governance model involves alterations in a nursing division's philosophical base, structure, decision-making processes, and in the roles and relationships of its members.

4. Values and beliefs about the sharing of control form the basis for developmental decisions. These values and beliefs are not static, but are continually in a process of change. Development of a shared governance model is therefore an ongoing process.

5. Development of a shared governance model is a group process characterized by political activity. Achievement of consensus occurs within the context of negotiation and compromise by representatives of stakeholder groups.

6. Unionization and shared governance are both ideologies that compete for the loyalty of staff nurses.

7. A supportive nursing leader who can act as an advocate at the corporate level is critical to ongoing development of the model.

8. A sustained commitment at the corporate and divisional level to financially support the shared governance process is critical to ongoing development.

9. Feelings of exclusion in various stakeholder groups are a natural consequence of shifts in the sharing of control.

Nursing Implications

Nursing Administration and Nursing Staff

The process identified in this research may be useful to nurse administrators and staff nurses seeking to understand how a nursing division might accomplish the transformation to a shared governance system. While some authors have indicated 3 to 10 years as the developmental period required to achieve shared governance (Eckes, 1988; Jacoby & Terpstra, 1990; Jenkins 1991; and Maas, 1989), the researcher found that the process at the study hospital involved a journey of discovery and change that was ongoing. Participants did not ever "arrive" at shared governance, for the definition of the destination was constantly changing as beliefs and values about the sharing of control were further refined. Changes in sharing control were small, involved learning from previous cycles, and occasionally involved temporary reversion to a more familiar and safer way of sharing control during times of stress or uncertainty. Nursing Administrators and staff nurses choosing to implement shared governance therefore need to be patient, to concentrate on celebrating small changes as evidence of progress, and to accept both progression and reversion as a part of the process. It is hoped that recognition of the integral part played by dissatisfaction in the process of *Making Changes* at the study hospital may encourage nursing administrators and staff nurses to consider indicators of dissatisfaction more positively and to plan their responses accordingly.

Information on the strategies used to establish the model and on the salient factors impacting both movement and choice also may be useful for nursing administrators implementing shared governance in similar settings. The influence of the nursing union may be of particular interest. As seen at the study hospital, nurse administrators initiating shared governance in unionized hospitals must have the "buy in" of the Union, must be cognizant of the limitations placed on staff involvement, and should be prepared to negotiate changes in traditional management roles at the bargaining table. Involving staff and management in common decision-making forums has the potential of undermining the union's traditional role. Resistance may be expected. At the study hospital, the Union was instrumental in initiating both Cycles B and C and played a major role in the decision to abstain from involvement in governance activities in Cycle E.

Nursing Research

The research method chosen appears to represent an innovative approach to research on models of shared governance. As indicated in the literature review in Chapter II, no studies were found that focussed explicitly on defining the process used to develop a shared governance model and little information was found that described the role played by unions in developing such a model. Verification of the process, the impact of unionization on the model's development, and the influencing factors identified in this study requires further research in other nursing divisions with shared governance systems. Another area of potential research is whether the process identified remains true for more mature systems (> 10-15 years) or is unique to younger systems (< 5 years post implementation).

Strengths and Limitations

The researcher's intent in doing the study was not to provide a historical account of the activities engaged in by participants as they developed their shared governance model. The intent was theory generation, that is, to develop a model of the particular process used at the study hospital that would explain how development of shared governance over the three year period occurred. The grounded theory method provided the researcher with a systematic approach to generating theory. A major strength of the grounded theory method is that the theory generated arises out of the experiences of participants and is verified by participants involved in the phenomenon under study. The process of ***Making Changes*** identified in this study therefore represents a verified translation into conceptual terms of the unique experiences of nurses in the study hospital with the development of shared governance. An additional strength of this research method is that it provides an opportunity for gaining rich insights from participants that otherwise might not have emerged.

Limitations of this study include the inability to obtain informants who could offer the 'official' Union perspective, the impact of an economic crisis occurring one month into the study on data sources and the research process, the mainly retrospective nature of the study, and the potential influence on study findings of the researcher's employment in the study hospital. The lack of informants to represent the official union perspective does not invalidate the process identified. Official union views explicitly recorded in council and committee minutes were included in data analysis. Identification of the factors impacting process and choice arose primarily out of informant interviews and may be limited by the absence of an official union perspective. A similar effect may result from the greater number of management versus staff nurse informants.

The economic crisis negatively influenced the availability of a functioning shared governance model and the procurement of informants. In August 1993, a hold placed on governance activities precluded further study of the New Model. The threat of impending layoffs also prompted the researcher to hasten procurement and interviewing of informants. The consequence was that, in contrast to the ideal of concurrent data gathering and analysis, the bulk of the work of analyzing and theoretically sampling occurred after completion of all informant interviews. The impact of this variation in method on the study findings is unknown.

Difficulty with informant recall due to the retrospective nature of the study was offset by the inclusion of council and committee minutes as a data source. These minutes were particularly helpful in establishing a ordered pattern for the process identified. Questions about forgotten events arising from the minutes also stimulated informant recall of related events and brought to the surface difficulties initially forgotten.

It is possible that the researcher's past and current employment at the Study Hospital reduced the researcher's objectivity. Though the researcher attempted to reduce the impact of personal biases on the study findings, the researcher was aware of a tendency to view the data using a management perspective. Positive effects from the researcher's employment also occurred. Past relationships with six informants facilitated the formation of trust and prompted these informants to be more forthright. The researcher's current staff nurse position seemed to forge a common bond with the four informants previously unknown to the researcher, who were also affected the restructuring occurring at the study hospital. These informants openly shared positive and negative perceptions of their experience with the model's development.

Summary

Discussion in this chapter focussed on exploring the study findings in the context of current literature, identifying propositional statements, summarizing implications, and discussing the study's strengths and limitations. The process identified in this research is grounded in data arising from one nursing division's experience with the ongoing process of developing a shared governance model. Further research is required to substantiate the process identified and to expand understanding of what remains, in nursing, a largely unexplored phenomenon.

References

Allen, L. (1991). Implementing shared governance: Models for empowering teachers. Chicago, IL: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 334 680)

Anderson, B. (1992). Voyage to shared governance. Nursing Management, 23(11), 65-67.

Becker, C. (1986). Interviewing in human science research. Methods, 1, 101-124.

Bondy, E., Kilgore, K., Ross, D., & Webb, R. (1994). Building blocks and stumbling blocks: Three cases of shared decision making and school restructuring. New York, NY: Colombia University, Teachers College National Center for Restructuring Education, Schools, and Teaching. (ERIC Documentation Reproduction Service No. ED 376 578)

Bredeson, P. V. (1989). Redefining leadership and the roles of school principals: Response to changes in the professional worklife of teachers. San Francisco, CA: Paper presented at Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 304 782)

Burgett, J. C. (1993). A plan for implementation of shared governance in the community hospital (Masters dissertation, Bellarmine College, 1993). Masters Abstracts International, 31(03), 1730.

Burke, B. E. (1991). Shared governance - Canadian application. Nurse to Nurse, 2(2), 42-43.

Byrk, A. S., Easton, J. Q., Kerbow, D., Rollow, S. G., & Sebring, P. A. (1993). A view from the elementary schools: The state of reform in Chicago. Chicago, IL: Consortium on Chicago School Research. (ERIC Document Reproduction Service No. ED 361 444)

Caramanica, L., & Rosenbecker, S. (1991). A pilot approach to shared governance. Nursing Management, 22(1), 46-48.

Center on Organization and Restructuring of Schools. (1992). Issues in restructuring schools. Washington, DC: Office of Educational Research and Improvement. (ERIC Document Reproduction Service No. ED 351 793)

Charles, G. S., & Karr-Kidwell, P. J. (1995). Effective principals. Effective schools. Arriving at site-based decision-making with successful principals and teacher. TX: Texas Woman's University. (ERIC Document Reproduction Service No. ED 382 564)

Chenitz, W. C., & Swanson, J. M. (1986). From practice to grounded theory: Qualitative research in nursing. Meleno Park, CA: Addison-Wesley.

Chion-Kenney, L., & Hymes, D. L. (1994). Site-based management and decision-making: Problems and solutions. Arlington, VA: American Association of School Administrators. (ERIC Document Reproduction Service No. ED 379 755).

Chorewycz, M. (1994). A study of five school-based management projects over a four year period (Doctoral dissertation, University of Minnesota, 1994). Dissertation Abstracts International, 55(03), 428A.

Cleland, V. S. (1978). Shared governance in a professional model of collective bargaining. Journal of Nursing Administration, 8(5), 39-43.

Cohen, S. G., & Ledford, G. E. (1994). The effectiveness of self-managing teams: A quasi-experiment. Human Relations, 47(1), 13-43.

Conley, D.T. (1993). Roadmap to restructuring: Policies, and the emerging visions of schooling. Washington, DC: Office of Educational Research and Improvement. (ERIC Document Reproduction Service No. ED 359 593)

Cooper, H. M. (1982). Scientific guidelines for conducting integrative research reviews. Review of Educational Research, 52(2), 291-302.

Coradetti, W. R. (1994). Teamwork takes time and a lot of energy. HRMagazine, 39(6), 74-77.

Daniel, B. (1995). The effectiveness of shared governance in a community hospital (Masters dissertation, California State University, Dominguez Hills, 1994). Masters Abstracts International, 33(06), 1835.

Davis, P. A. (1992). Unit-based shared governance: Nurturing the vision. Journal of Nursing Administration, 22(12), 46-50.

DeBaca, V. Jones, K., & Tornabeni, J. (1993). A cost-benefit analysis of shared governance. Journal of Nursing Administration, 23(7/8), 50-57.

Deremo, D. E. (1989). Integrating professional values, quality practice, productivity, and reimbursement for nursing. Nursing Administration Quarterly, 14(1), 9-23.

Deremo, D. E. (1990). Henry Ford hospital: The journey toward a professional reality. In K. J. McDonagh (Ed.), Nursing shared governance: Restructuring for the future (pp. 65-96). Atlanta, GA: K. J. McDonagh & Associates.

Eckes, A. (1988). Implementing shared governance: A process for growth. In S. E. Pinkerton & P. Schroeder (Eds.), Commitment to excellence: Developing a professional nursing staff (pp. 123-127). Rockville, Md: Aspen.

Edwards, G., Farrough, M., Gardner, M., Harrison, D., Sherman, M., & Simpson, S. (1994). Unit-based shared governance can work! Nursing Management, 25(4), 74-77.

Ethridge, P. (1987). Nurse accountability program improves satisfaction, turnover. Health Progress, 68, 44-49.

Ferguson, M. (1980). The Aquarian Conspiracy. Los Angeles, CA: Tarcher.

Field, P. A., & Morse, J. M. (1985). Nursing research: The application of qualitative approaches. Rockville, MD: Aspen.

Firestone, W. A., & Bader, B. D. (1991). Professionalism or bureaucracy? Redesigning teaching. Educational Evaluation and Policy Analysis, 13(10), 67-86.

Foster, B. E. (1992). Models of shared governance: Design and implementation. In T. Porter-O'Grady (Ed.), Implementing Shared Governance: Creating a professional organization (pp. 79-110). St. Louis MO: Mosby Year Book.

Glaser, B. (1978). Theoretical sensitivity. San Francisco, CA: Mill Valley.

Glaser, B., & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. New York, NY: de Gruyter.

Glickman, C. D., Allen, L., & Lunsford, B. (1992). Facilitation of internal change: The league of professional schools. San Francisco CA: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 347 929)

Gomberg, S., & Sinesi, L. (1994). A collaborative interaction model and the implementation of shared governance. Holistic Nursing Practice, 8(3), 12-21.

Graham, R. J. (1993). Effectiveness in self-managed teams and traditional work groups (Doctoral dissertation, University of Denver, 1992). Dissertation Abstracts International, 53(08), 4404B.

Gyongyos, J. D. (1988). Shared governance: A human resources viewpoint. Aspen's Advisor for Nurse Executives, 4(2), 1, 6-7.

Hackman, J. R. (1976). The psychology of self-management in organizations. In M. S. Pollack & R. O. Perloff (Eds.), Psychology and work: Productivity change and employment (pp. 85-136). Washington, DC: American Psychological Association.

Hastings, C., & Waltz, C. (1995). Assessing the outcomes of professional practice redesign. Journal of Nursing Administration, 25(3), 34-42.

Havens, D. S. (1990). Analysis of the nature and extent of implementation and projected implementation of a model proposed to support professional nursing practice in acute care general hospitals (Doctoral dissertation, University of Maryland at Baltimore, 1990). Dissertation Abstracts International, 51(11), 5245B.

Havens, D. S. (1994). Is governance being shared? Journal of Nursing Administration, 24(6), 59-64.

Hibberd, J. M., Storoz, C. E., & Andrews, H. A. (1992). Implementing shared governance: A false start. Nursing Clinics of North America, 27(1), 11-22.

Houston, S. & Green, S. (1993). The CNS role: Evolution within a shared governance environment. Clinical Nurse Specialist, 7(2), 87-90.

Jacoby, J., & Terpstra, M. (1990). Collaborative governance: Model for professional autonomy. Nursing Management, 21(2), 42-44.

Jenkins, J. (1988). A nursing governance and practice model: What are the costs? Nursing Economic$, 6(6), 302-311.

Jenkins, J. E. (1991). Professional governance: The missing link. Nursing Management, 22(8), 26-28, 30.

Johnson, L. M. (1992). Structures, strategies, and synthesis: The nurse executive as social architect. Nursing Administration Quarterly, 17(1), 10-16.

Johnson, M., & Ledbetter, L. (1993). The critical role of the principal in a shared decision-making schoool. Atlanta Ga: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 360 719)

Jones, C. B., Stasiowski, S., Simons, B. J., Boyd, N.J., &

Lucas, M.D. (1993). Shared governance and the nursing practice environment. Nursing Economics, 11(4), 208-214.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. The American Journal of Occupational Therapy, 45(3), 214-222.

Krueger Wilson, C. (1989). Shared governance: The challenge of change in the early phases of implementation. Nursing Administration Quarterly, 13(4), 29-33.

Kvale, S. (1983). The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. Journal of Phenomenological Psychology, 14(2), 171-196.

Lawler, E. E., & Mohrman, S. A. (1987). Unions and the new management. The Academy of Management Executive, 1(3), 293-300.

Lewin, K. (1951). Field theory in social science. New York, NY: Harper Brothers.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Locke, E, A. & Schweiger, D. M. (1979). Participation in decision-making: One more look. Research in Organizational Behavior, 1, 265-337.

Ludemann, R. S., & Brown, C. (1989). Staff perceptions of shared governance. Nursing Administration Quarterly, 13(4), 49-56.

Lukens Steel Company. (1996). A testing ground for total quality at Lukens. Iron Age New Steel, 12(2), 22-26.

Lunsford, B. (1993). The voice of the principal in shared governance. Atlanta GA: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. EA 025 188)

Maas, M. L. (1989). Professional practice for the extended care environment: Learning from one model and its implementation. Journal of Professional Nursing, 5(2), 66-76.

Mahugh, M. J. (1993). Shared governance: Effects of nurse decision-making (Masters dissertation, San Jose State University, 1993). Masters Abstracts International, 31(03), 1206.

Malen, B. & Ogawa, R. T. (1985). The implementation of the Salt Lake City School District's policy: A study of school-site councils. Salt Lake City, UT: Salt Lake City School District. (ERIC Document Reproduction Service No. ED 274 099)

Mancini, V. T. (1991). The relationship between a shared governance management structure and registered nurse job satisfaction: a comparison of two hospitals (Doctoral Dissertation, University of Massachusetts, 1990), Dissertation Abstracts International, 51(11), 5246B.

Manz, C. C. (1990). Beyond self-managing work teams: Toward self-leading teams in the workplace. Research in Organizational Change and Development, 4, 273-299.

Manz, C. C., & Sims, H. P. (1984). Searching for the "unleader": Organizational members views on leading self-managed groups. Human Relations, 37(5), 409-424.

Manz, C. C., & Sims, H. P. (1987). Leading workers to lead themselves: The external leadership of self-managing work teams. Administrative Science Quarterly, 32, 106-128.

McDonagh, K. J. (1990). Model comparison: How three nursing shared governance model compare. In K. J. McDonagh (Ed.), Nursing shared governance: Restructuring for the future (pp. 97-113). Atlanta, GA: K. J. McDonagh & Associates.

McDonagh, K. J., Rhodes, B., Sharkey, K., & Goodroe, J, H. (1989). Shared governance at Saint Joseph's hospital of Atlanta: A mature professional practice model. Nursing Administration Quarterly, 13(4), 17-28.

McLean, B. (1995). Perceptions of a change process: the development of a shared governance model. Unpublished masters dissertation, University of Alberta, Edmonton.

McMahon, J. M. (1992). Shared governance: The leadership challenge. Nursing Administration Quarterly, 17(1), 55-59.

Minors, S. P. (1993). A twelve group time series analysis of job satisfaction and financial effects of nursing shared governance (Doctoral dissertation, Georgia State University, 1993). Dissertation Abstracts International, 54(03), 1312B.

Monk, M. (1994). Nursing Governance. In J. M. Hibberd & M. E. Kyle (Eds.), Nursing management in Canada (pp. 191-211). Toronto, Ont.: W. B. Saunders Canada.

Morse, J. M., & Johnson, J. L. (1991). The illness experience: Dimensions of suffering. Newbury Park, CA: Sage.

Motz, D., & Lewis, J. (1994). Shared goverance: Is it a catalyst of change? Journal of Burn Care & Rehabilitation, 15(4). 375-385.

Mullins Moore, V., Morselander, S. B., & McDonagh, K. J. (1990). Saint Joseph's Hospital of Atlanta: A decade of success. In K. J. McDonagh (Ed.), Nursing shared governance: Restructuring for the future (pp. 45-64). Atlanta, GA: K. J. McDonagh & Associates.

Murphy, C. (1995). The school council as an agent of change: a comparative study (Doctoral dissertation, University of North Texas, 1995). Dissertation Abstracts International, 56(05), 1608A.

Nolte, C. (1994). An ethnographic study of leadership and decision-making in six school-based councils (Doctoral dissertation, Virginia Commonwealth University, 1994). Dissertation Abstracts International, 55(05), 1159A.

Oswald, L. J. (1995). School-Based management. ERIC digest, number 99. Washington, DC: Office of Educational

Research and Improvement. (ERIC Document Reproduction Service No. ED 384 950)

Perry, F., & Code, S. (1991). Shared governance: A Canadian experience. Canadian Journal of Nursing Administration, 4(2), 27-28, 30.

Peterson, K., Gok, K., & Warren, V. (1995). Principals skills and knowledge for shared decision making. Madison, WI: Center on Organization and Restructuring of Schools. (ERIC Document Reproduction Service No. ED 386 827)

Peterson, M. E., & Allen, D. G. (1986a). Shared governance: A strategy for transforming Organizations. Journal of Nursing Administration, 16(1), 9-12.

Peterson, M. E., & Allen, D. G. (1986b). Shared governance: A strategy for transforming Organizations. Journal of Nursing Administration, 16(2), 11-16.

Pinkerton, S. E. (1988). Evaluation of shared governance in a nursing department. In M. K. Stull & S. Pinkerton (Eds.), Current strategies for nurse administrators (pp. 141-150). Rockville, MD: Aspen.

Pinkerton, S. E., Eckes, A., Marcouiller, M., McNichols, M. B., Krejci, J. W., & Malin, S. (1989). St. Michael Hospital: A shared governance model. Nursing Administration Quarterly, 13(4), 35-47.

Porter-O'Grady, T. (1987). Shared governance and new organizational models. Nursing Economics, 5(6), 281-286.

Porter-O'Grady, T. (1989). Shared governance: Reality or sham? American Journal of Nursing, 89(3), 350-351.

Porter-O'Grady, T. (1991a). Shared governance for nursing Part 1: Creating the new organization. AORN Journal, 53(2), 458-466.

Porter-O'Grady, T. (1992). Of rabbits and turtles: A time of change for unions. Nursing Economics, 10(3), 177-182.

Porter-O'Grady, T., & Finnigan, S. (1984). Shared governance for nursing: A creative approach to professional accountability. Rockville, MD: Aspen Systems.

Porter-O'Grady, T., & George, V. (1996). A mature shared governance system: More structure than substance. Journal of Nursing Administration, 26(2), 14-19.

Porter-O'Grady, T., & Tornabeni, J. (1993). Outcomes of shared governance: Impact on organization. Seminars for Nurse Managers, 1(2), 63-73.

Reece, G.T. (1991). Learning to restructure schools: Lessons from the Stearns school model. Washington DC: Office of Educational Research and Improvement. (ERIC Document Reproduction Service No. ED 342 130)

Robinson, C. A. & Thorne, S. C. (1988). Dilemmas of ethics and validity in qualitative nursing research. Canadian Journal of Nursing Research, 20(1), 65-76.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Shidler, H., Pencak, M., & McFolling, S. (1989). Professional nursing staff: A model of self-governance for nursing. Nursing Administration Quarterly, 13(4), 1-9.

Short, P. M. & Greer, J. T. (1989, March). Increasing teacher autonomy through shared governance: Effects on policy making and student outcomes. San Francisco, CA: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 319 096)

Sidener, R. P. (1995). Site-based management/shared decision-making: A view through the lens of organizational culture. San Francisco, CA: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 383 105)

Smith, S. (1992). Nursing staff roles in unfolding shared governance. In T. Porter-O'Grady (Ed.), Implementing Shared Governance: Creating a professional organization (pp. 111-140). St. Louis MO: Mosby Year Book.

Smith, W. E. (1993). Teacher's perception of role change through shared decision-making: A two-year case study. Atlanta GA: Paper presented at the Annual Meeting of the American Educational Research Association. (ERIC Document Reproduction Service No. ED 360 299)

Stern, P. N. (1985). Using grounded theory method in nursing research. In M. M. Leininger (Ed.), Qualitative research methods in nursing (pp. 140-160). New York, NY: Grune & Stratton.

Stichler, J. F. (1989). Shared governance: What it means to those involved. Aspen's Advisor for Nurse Executives, 4(9), 2-3, 6-8.

Tuckman, B. W. (1965). Developmental sequence in small groups. Psychological Bulletin, 63(6), 384-399.

Twite, K., Herman, R., Katz, S., & Sweeney, F. (1993). Career scope: North Central. Nursing Management, 24(3), 68-69.

Twomey, W. E. (1991). Negotiating a shared governance program in a unionized hospital - a road less travelled. Aspen's Advisor for Nurse Executives, 6(7), 1, 3-5.

Walker, D., Jones, S., Yamouchi, S., Lima, C., Archer, S., Mathews, B., Harris, M., Kamikawa, C., Irvine, N., Lanier, J., Verderber, A., & Knoll, S. (1994). On the scence: The Queen's Medical Center Honolulu, Hawaii. Nursing Administration Quarterly, 19(1), 33-65.

Westrope, R.A., Vaughn, L., Bott, M., & Lee Taunton, R. (1995). Shared Governance: From vision to reality. Journal of Nursing Administration, 25(12), 45-54.

Wong, R., Gordon, D., Cassard, S., Weisman, C. & Bergner, M. (1993). A cost analysis of a professional practice model for nursing. Nursing Economics, 11(5), 292-297.

Zelauskas, B., & Howes, D. G. (1992). The effects of implementing a professional practice model. Journal of Nursing Administration, 22(7/8), 18-23.

APPENDIX A

Letter of Introduction

Dear _________________________,

My name is Leslie Nelson and I am a Master's in Nursing student at the University of Alberta. As part of my degree, I am doing a study on how the decision-making structures and processes of shared governance were developed in this nursing division. This study has been evaluated by and has the support of the Shared Governance Evaluation Task Force at the hospital.

I am interested in hearing about your experience with the development of the shared governance model. Would you consider taking part in the study? The results of this study will provide beginning information that will be useful to other staff nurses, nurse managers, and nurse administrators who may also be interested in developing a model of shared governance in their nursing division.

The study involves interviews between yourself and I, in a place of your choosing. I will not tell anyone who is taking part in the study, nor will any names of those interviewed appear in any publication or presentation of the study's results.

I would be happy to discuss details about the study and to answer any questions that you may have. Please call me at XXX-XXXX. If, after talking about the study, you wish to participate, we can set a time and place for the interview. If I am not home please leave a message on my answering machine and I will return your call as soon as possible.

Thank-you,

Leslie Nelson.

APPENDIX B

Consent Form

Project Title: Identifying Relevant Factors in the Development of Shared Governance Decision-Making

Investigator: Leslie S. Nelson, Master's in Nursing Candidate. University of Alberta, Edmonton, Alta.

Thesis Chairperson: Dr. Judith Hibberd, Associate Professor, University of Alberta Faculty of Nursing

Purpose of Study: The purpose of the study is to provide beginning information, useful to nurse administrators, nurse managers, and staff nurses, about: 1. how the structures and processes of shared governance decision-making can be developed.
2. what factors may need to be considered when developing these structures and processes.

Participation:

There will be no harm to you if you take part in this study nor will you benefit directly from the study. Results from this study will be useful to the study hospital in its efforts to understand the beginning development of the shared governance model.

You are free to choose, without fear of consequence, whether to be a part of this study or not. If you decide to be in this study, you may drop out at anytime by telling the researcher. Taking part in this study or deciding to drop out will not affect your job at the study hospital.

If you choose to be part of the study, you will be interviewed by the researcher and the interviews will be tape recorded and then typed. One to three interviews may be needed, each lasting about an hour. You do not have to answer any questions or discuss any subject in the interview if you don't want to.

Your name will not appear in this study. Only a code, known to the researcher will appear on any forms. The researcher will erase any identifying material from the tapes. All material will be stored in locked file cabinets when not in use. Consent forms will be stored in a different file than the tapes and typewritten records. Seven years after completion of the study the tapes will be destroyed. The typed interview and notes will remain in a locked file. The typed interview and notes may be used in another study in the future after approval from the appropriate ethical review committee.

The information and findings of this study may be published or presented at conferences. Your name or any comments made by you will not be identifiable. The name of the study hospital will not appear in any written material or talks given unless prior permission is obtained from the study hospital. During the study, if you have any questions or concerns about this study you may call the researcher, Leslie Nelson at XXX-XXXX.

Consent: Any questions that I may have had about the study and my part in it have been answered to my satisfaction. I understand the contents of this consent form and am aware that I may drop out of the study at any time, by telling the researcher. I agree to participate in this study. I have been given a copy of this consent form and the letter of introduction to keep.

(Signature of Participant) **(Date)**

(Signature of Researcher) **(Date)**

If you wish a copy of the research findings, please complete the next section or call Leslie Nelson at XXX-XXXX:

(Name)

(Address)

APPENDIX C

Letters of Support

In order to protect the identity of the Study Hospital, the original letters of support from the VPN and the shared governance research committee remain in the possession of the researcher and are not reproduced in the thesis.

APPENDIX D

Examples of Guiding Interview Questions

Tell me about your involvement with the development of the shared governance model.

What did the original model consist of?

How was the current model of shared governance developed?

How does decision-making occur in the model?

What authority for decision-making exists in the model?

What was the role of the nurses' association during the model's development?

What things helped or hindered the development of the model?

Tell me about how people worked together to develop the model?

If you had a chance to do it over again, what things would you change?

APPENDIX E

Subject Face Sheet

Position Status:

Nurse Administrator__ Nurse Manager__ Director __
Clinical Supervisor__ Staff nurse __ Union
Representative __

Highest Educational Level Achieved

Diploma RN__
Bachelor in Nursing __
Bachelor - other __
Masters in Nursing__
Masters - other __
Doctorate in Nursing__
Doctorate - other __

Sex

Male __ Female__

Years of Experience in Nursing Field

< 5 years __ 5-09 years __ 10-14 years __
> 15 years __

When did you get involved with the development of the shared governance model? What have you been involved with?

What prompted you to get involved?

APPENDIX F

Summary of Informant Face Sheet Values

Group	Years of Experience in Nursing Field				
	<4	4-5	6-8	11-14	20+
Management	1	-	-	-	5
Staff Nurses	-	1	1	1	1

Group	Years Employed in Study Hospital				
	<4	4-5	6-8	11-14	20+
Management	1	1	-	2	2
Staff Nurses	-	1	1	1	1

Group	Level of Educational Preparation		
	Diploma	Bachelor	Masters /Doctorate
Management	1	2	3
Staff Nurses	1	3	0

APPENDIX G

Informant Involvement in the Development of Shared Governance

	Area of Involvement	Management	Staff
A	Old Model Council Structure Task Force Decision Task Force New Model Councils	2	0
B	Structure Task Force Decision Task Force New Model Councils	0	2
C	One Task Force New Model Councils	2	1
D	New Model Councils	2	1

Note. Categories A to D represent varying degrees of informant involvement in the development of shared governance during the study period.

Category A represents involvement in everything.

Category D represents involvement in one aspect, that is, only the New Model Councils.

APPENDIX H

Quotation Referencing System

Quotations from Informant Interviews:

References for informant quotations will include the data source, the informant number, and the interview number. I-01-02 or BIO-01-2, for example, refers to informant 1 and interview 2 in both cases. The source of the data, however, differs with "I" referring to the data collection interview and "BIO" referring to biographical, that is data originating from answers to the open ended questions on the Subject Face Sheet seen in Appendix C.

Quotations from Other Sources:

Pseudonyms, rather than the actual name of the council, committee, task force, or group are used in referencing quotations from relevant documents and from participant-observation of the new model councils. Copies of these documents will be stored with the informant interviews at the home of the researcher.